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Oncology Nurses' Perceptions of Self-Compassion: a Pilot Study

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the requirement for the degree of
Master of Arts in Nursing

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Department of Nursing
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Thesis or Graduate Project Approval Form

This is to certify that **Miriam Lindell** has successfully defended her Graduate Project entitled **"The Perceptions of Self-Compassion Among Oncology Nurses"** and fulfilled the requirements for the Master of Arts in Nursing degree.

Date of Oral defense **September 29, 2009.**

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Abstract

Oncology nurses face extraordinary stressors in their work. If this stress becomes prolonged, these nurses are at risk for burnout and compassion fatigue. One effective way for nurses to manage stress is to care for themselves, body, mind, and spirit. The concept of self-compassion reflects a meaningful approach to self-care. This pilot study explored the perception of self-compassion by hospital based oncology nurses. A convenience sample of 37 oncology nurses was surveyed using four demographic questions and the Self-Compassion Scale by Kristin Neff. The results demonstrated positive correlation between years of nursing experience and years of oncology nursing experience with common humanity, one aspect of self-compassion. Further research about self-compassion and nurses may help to increase nurses' understanding of self-care and effective workplace stress management.

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Chapter 1: Purpose

Over the past several years there has been increasing attention paid to the high levels of professional and personal stress in the nursing profession and the increased risk of burnout among nurses. Experiences of prolonged stress and the development of burnout are factors that contribute to the exodus of nurses from the profession which contributes to the growing shortage of nurses in this country. Nurses face extraordinary stressors in their environment including challenging work hours, staffing shortages, limited power over their workplace, emotional labor, and bearing witness to the suffering of their patients. Nurses are clearly at high risk for chronic stress and potential burnout. In addition to the physical and psychological problems that arise for nurses, the continued exposure to high levels of personal and professional stress can lead to decreased quality of care and a premature exit from the profession (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2004).

The U.S. Department of Health and Human Services, Health Resources and Services Administration, (2004) has projected that by 2015 there will be a shortfall of registered nurses of 27 percent, and by 2020 that number will increase to a shortfall of 36 percent. While the level of complexity and pace of work has increased in all areas of nursing, it especially impacts nurses working in hospital settings. The Agency for Healthcare Research and Quality, part of the Department of Health and Human Services, reports that hospital nursing vacancies will reach 29 percent by 2020, and that the number of registered nurses overall will only increase by 6 percent during that time (Stanton & Rutherford, 2004). According to the U.S. Bureau of Labor

Statistics, there will be 233,000 jobs for registered nurses opening each year till 2016, but there are only about 200,000 candidates that pass the RN board exams each year (Henry J. Kaiser Family Foundation, 2009).

The nursing shortage may not only be a shortage in numbers, but also "of highly educated nurses with acute care expertise and career longevity" (Hodges, Keeley, & Troyan, 2008, p. 80). The increasing rate of turnover and continuing loss of experienced nurses makes it more difficult to develop and maintain the necessary levels of nursing expertise in the acute care setting. "Approximately 60 percent of new graduate RNs leave their first job before the end of their first year" (Hodges et al., p. 80). The critical thinking and problem solving skills of highly educated, experienced nurses, and their ability to be patient educators and advocates, as well as leaders among their peers, is extremely important for creating and maintaining required levels of patient safety and high quality of care in acute care areas (Hodges et al.). If the challenges of increasing personal and professional stress among nurses are not met with effective responses, the loss of both numbers of nurses and crucial nursing expertise and knowledge will have a devastating impact on the quality of health care across the board. Hodges et al. (2008) point out that

> Disillusionment with bedside nursing and dehumanization of care precipitate early departure of even new nurses, exacerbating a recurrent dilemma to the nursing profession, to the health care arena, and to our society. Nursing's tradition of sacrificing self to the health care system does nothing to prepare professionals who are creative, positive, and who enjoy what they do (p. 89).

How do the health care industry and the nursing profession begin to solve this problem? How can leaders in health care and nursing not only slow the exodus but reverse the damaging trends and actually support the process of healing the profession of nursing? This is a very complex task and will require a multifaceted approach to culture change within the health care industry. Perhaps the first question to ask is how can health care and nursing leaders equip and support nurses to manage their individual ability to handle the high levels of stress? How can nurses change how they experience that stress?

The healing process for individual nurses, as well as for the nursing profession, needs to start with the practice of caring for self. This pilot study looks at one aspect of caring for self, the concept of self-compassion, and how oncology nurses perceive that concept within themselves. Nursing in general is stressful work, and oncology nursing in the hospital setting is an especially challenging field, and leads to significant experiences of personal and professional stress. The issues of stress and self care, and other related concepts, will be discussed here.

Stress

The concept of stress has been studied for the past century and developed out of the identification of the physiological fight or flight response in the early 1900s (Kemeny, 2003; Deckro, et al., 2002). When one perceives any kind of threatening stimulus, or stressor, one experiences both physical and psychological responses to that perceived threat. These responses have evolved to ready the individual to efficiently deal with the threat by facing it (fight) or escaping it (flight). The autonomic nervous system (ANS) plays a significant role in how a person responds to

a stressor. The sympathetic branch contributes to the stress response by supporting the physical systems needed urgently to respond to the perceived threat, while those systems that are less critical in an emergent situation are suppressed. The parasympathetic branch, on the other hand, controls the involuntary resting functions of the body, also called the relaxation response. These are physiological changes that are the opposite of those caused by the sympathetic branch and they allow the body to relax and replenish once the perceived threat has been removed (Kemeny; Deckro et al.).

When one experiences a stressor the sympathetic branch of the ANS is activated and leads to the release of nor epinephrine, epinephrine, also called adrenaline, cortisol, and blood glucose. These chemicals help prepare the body to respond to the perceived threat by increasing heart rate, respiratory rate, and blood flow to the large muscle groups, as well as causing the mental state to become sharper and more narrowly focused on the task ahead (Olofsson, Bengtsson, & Brink, 2003). On a short term basis the activation of the stress response is adaptive and promotes one's safety and security. When the stress response is repeatedly or chronically activated, it becomes maladaptive and can have a detrimental affect on one's physical and psychological health. It can lead to the malfunctioning of the immune system by reducing lymphocyte counts and suppressing the effectiveness of immunological cells which can lead to an increased risk of infection. It can also create a chronic inflammatory response which is known to contribute to a variety of diseases, and a release of certain cytokines which can induce negative moods and alter cognitive abilities (Kemeny, 2003).

While the physiological response to stress is an involuntary process, it has been found that one's cognitive appraisals of the perceived threat can significantly affect the manifestation of the physiological response (Kemeny, 2003). These appraisals include the perception of the threat to the goal of maintaining physical and psychological wellbeing as well as the perception of the resources available to meet the demands of the threat. Kemeny states that there are three main categories of cognitive appraisal. The first is one's motivational state, where one sees the stressful circumstance as either a threat or as a challenge. If one sees it as a challenge, there is less of a physiological stress response that occurs than if one sees it as a threat. Another category of cognitive appraisal is that of perceived control. Stressful circumstances that are perceived to be controllable create less of a physiological response than if they are perceived as uncontrollable. The third category is that of social cognition. If an individual perceives himself or herself as subordinate, or of a lower social status, there will be higher level of physiological stress response than if one perceives being in a dominant position. Because these cognitive appraisal factors produce differences in the physiological stress response, the way a person thinks about a stressor has the potential to change the physiological impact of that stressor (Kemeny).

All kinds of life circumstances can be perceived as stressors, including personal life, social interactions, and workplace experiences. Workplace stress is a significant occupational hazard that can impair physical and psychological health and can have a negative impact on work performance (Sherman, 2004). Factors that may increase job stress for nurses include perception of an external locus of control,

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inability to adequately express feelings and emotions, and a tendency towards neuroticism, described as having increased feelings of guilt, anxiety, irritability and depression (Buhler & Land, 2003). Experiencing a lack of effective leadership from managers or supervisors may also contribute to increased stress for nurses. Minimal or no involvement in decision-making, lack of clarity with roles and expectations, poor communication patterns, and feedback being given only in the context of identifying errors, all are characteristics of poor leadership that add to workplace stress for nurses (Stordeur, D'hoore, & Vandenburghe, 2001; Edward & Hercelinskyj, 2007). Other common organizational contributors to workplace stress include work overload, social conflict, and a lack of resources needed to get the job done (Maslach, 2003).

The phenomenon of complexity compression is another source of increasing work related stress for nurses. This is described as "what nurses experience when expected to assume additional, unplanned responsibilities while simultaneously conducting their multiple responsibilities in a condensed time frame" (Krichbaum, et al., 2007, p. 86). Significant workplace stressors for nurses include not only the emotional demands of caring for patients, but also the lack of time for planning and preparing for work, frequent work interruptions, and the expectation of responsibility without the appropriate decision-making power (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000).

Burnout

When the experience of workplace stress becomes prolonged or chronic, it often leads to burnout. Burnout is a phenomenon of three primary characteristics,

identified as emotional exhaustion, cynicism, and feelings of inefficacy (Maslach, 2003). Burnout is not a symptom of work related stress but is the end result of ineffective coping skills and long term, continued exposure to an emotionally demanding and stressful workplace (Altun, 2002; Edward & Hercelinskyj, 2007; Arafa, Nazel, Ibrahim, & Attia, 2003). Burnout can be described as the process in which there are negative changes in an employee's attitude and behavior in response to job strain. It is triggered by factors in the work environment such as frustration, powerlessness, and an inability to achieve work goals. There is a disconnect that exists between the expectation of the individual around role performance and the structure of the organization to support the professional role, leading to a gradual wearing down of the individual over time due to persistent, unresolved stress (Sabo, 2006).

Compassion Fatigue

Compassion fatigue is another concept that can be related to work stress and burnout. Schwam (1998) states that compassion fatigue is a phenomenon associated with workers who care for victims of traumatic events. It results from the emotional burden that health care providers may experience as a result of overexposure to traumatic events experienced by their patients. Unlike burnout, which develops over time, compassion fatigue has a more acute onset, and is a psychological assault on an individual that is overwhelming. Because it is a form of response to secondary trauma, the symptoms of compassion fatigue can be similar to those experienced by victims of post-traumatic stress disorder, including hyperarousal, intrusive images and avoidance behaviors (Sabo, 2006). Also, unlike burnout, compassion fatigue is a

response to the challenge of caring for patients who are intensely suffering, where burnout is more of a response to challenges of the work environment. The presence of burnout increases the risk of developing compassion fatigue (Sabo).

Abendroth and Flannery (2006) state that some key predictors of an increased risk of compassion fatigue include trauma, anxiety, life demands, and excessive empathy which may lead to blurring of professional boundaries. The risk of compassion fatigue is increased when nurses demonstrate a lack of self-care. McMullen (2007) states that compassion fatigue develops from "the constant expenditure of empathy, literally caring until it hurts" (p. 491). It is a sudden, acute stress response that leads to physical, emotional, and spiritual fatigue or exhaustion, and may cause a decline in an individual's ability to experience joy or care for others.

Self-Care

One of the most effective ways to mitigate the damaging effects of ongoing stress and to reduce the risk of burnout and compassion fatigue is through the process of caring for oneself on a continual basis, body, mind, and spirit. By cultivating self-awareness, constructive coping skills, emotional health, and positive psychosocial relationships, one can strengthen one's ability to effectively manage the experience of both personal and professional stress throughout one's life.

There is a growing demand for change, both from the profession of nursing as well as society at large, for a change in the culture and provision of health care. There is an increased awareness of the need to acknowledge the value of compassion and caring, the value of creativity and autonomy in the workplace, and the value of the feelings of belonging and interconnectedness with others (Turkel & Ray, 2004).

It is essential to acknowledge that the power of caring for self is critical for making this shift to a more caring, supportive, and empowering work environment (Turkel & Ray). If the nurse doesn't view or value himself or herself as a caring person or deserving of receiving care, it is not possible for him or her to provide authentic, compassionate care for others.

The American Holistic Nurses' Association identifies nurse self-care as one of the core values of holistic nursing practice. By integrating the value of self-care into its Scope and Standards of Practice, the American Holistic Nurses' Association is emphasizing that self care is not only a personal endeavor but is an expectation of professional nursing practice. Self-awareness and self-care are seen as ways to support oneself as an instrument of healing in one's practice of nursing in any setting (American Holistic Nurses Association, 2007).

Self-Compassion

A significant aspect of the holistic practice of self care is self-compassion. This is a relatively new concept that has been primarily studied by psychologists. It has been researched in a variety of populations, but it has not yet been studied among nurses. The concept of self-compassion has evolved out of the influence of eastern philosophy, specifically Buddhism, on the field of western psychology.

To define self-compassion one can first examine the general meaning of compassion. Sabo (2006) states "compassion is the experience of feeling with another while recognizing that the feelings of one are not the same as another – compassion promotes equality as experiencing compassion suggests an inherent regard and respect for the other as a fellow human being"(p. 136). According to Neff (2003)

"compassion involves being touched by the suffering of others, opening one's awareness to others' pain and not avoiding or disconnecting from it, so that feelings of kindness toward others and the desire to alleviate their suffering emerge"(p. 87). It also includes practicing non-judgmental understanding of the failures or mistakes of others by seeing others in the context of shared human fallibility (Neff, 2003). The concept of self-compassion reflects the process of turning the compassion one feels for others towards oneself. It includes the practice of self-kindness, the perception of oneself as part of common humanity, and the practice of mindfulness, or balanced awareness of thoughts and feelings (Neff, 2003).

Self-compassion could be seen as one manifestation of the cognitive appraisal processes that can impact one's experience of the stress response. There are some other concepts somewhat similar to self-compassion that have been studied in relation to stress, burnout and compassion fatigue for nurses that could also considered aspects of caring for oneself. These include mindfulness, emotional intelligence, and resilience. These concepts may also reflect the cognitive appraisal processes that can impact one's experience of the stress response.

Mindfulness

Mindfulness, which is actually one aspect included in the practice of self-compassion, is often discussed as a separate concept. The qualities associated with mindfulness include non-judgment, acceptance, patience, stability, and kindness (Cohen-Katz, et al., 2004). In the United States, the concept of mindfulness is commonly associated with the practice of Mindfulness Based Stress Reduction, a training program that incorporates the qualities of traditional Buddhist mindfulness

meditation into a stress management and self-care program. This program is applicable in many situations and accessible to a wide audience. Mindfulness is a moment to moment awareness, an intentional attempt to be in the reality of the present moment without getting caught up in the thoughts and emotional reactions to the current situation. It does not create the absence of negative thoughts and emotions; rather, with mindfulness practice, one can learn to be less caught up in them (Cohen-Katz, et al.).

Emotional Intelligence

Emotional intelligence is a relatively new concept that has been identified as an influential factor in personal and professional development and performance. It can be described as the ability to be personally and socially competent by demonstrating self awareness, self management, social awareness, and social or relationship management (Kooker, Shoultz, & Codier, 2007). Goleman (1995) describes emotional intelligence as having five basic domains: the knowledge of one's emotions, the management of one's emotions, the motivation of oneself, the ability to recognize emotions in others, and the ability to handle relationships through effective interpersonal skills.

Demonstrating emotional intelligence may lead to greater adaptability, improved relationships and movement towards more positive values and attitudes, as well as the development of a mature and responsible professional identity (Akerjorder & Severinsson, 2007). Emotional intelligence involves skills that can be taught and learned, and often will improve with age and maturity (Vitello-Cicciu, 2003; Freshwater & Stickley, 2004).

Resilience

Resilience can be described as "the combination of abilities and characteristics that interact dynamically to allow an individual to bounce back, cope successfully, and function above the norm in spite of significant stress or adversity" (Tusaie & Dyer, 2008, p 3). Resilience can also be defined as "the ability of an individual to bounce back from adversity, persevere through difficult times, and return to a state of internal equilibrium or a state of healthy being" (Edward, 2005, p. 142.) Areas where one may demonstrate resilience include work or school performance, behavioral and psychosocial adjustment, and physical health. Individuals may have more resilient abilities in some areas and not as much in others (Tusaie & Dyer, 2008).

Resilience encompasses both intrapersonal and environmental factors. Intrapersonal factors include optimism, intelligence, creativity, humor, and appreciation for one's own uniqueness. Environmental factors include perceived social support and a sense of connectedness (Tusaie & Dyer, 2008). Demonstrating resilience as a coping strategy is a skill that can be learned and may be fostered through role modeling and education (Warelow & Edward, 2007). Resilience has the potential for change and plasticity and exists across the course of life (Tusaie & Dyer).

Theory

When studying a particular problem, such as the issue of stress for nurses, and seeking a solution to that problem, it is helpful to approach it from a selected theoretical framework that may guide the process of research through gathering, processing, and interpreting data and disseminating results. Theory may be defined as

"a creative and rigorous structuring of ideas that projects a tentative, purposeful, and systematic view of phenomena" (Chinn & Kramer, 2008, p. 182). Nursing theory develops out of a combination of patterns of knowing which include emancipatory knowing, ethical knowing, personal knowing, aesthetic knowing and empirical knowing. In the practice of nursing, knowing is experienced as a whole, but it is possible to see the unique contributions of each of these patterns towards that whole (Chinn & Kramer).

Nursing theories serve a variety of purposes, including addressing specific concerns of clinical practice, understanding phenomena that occur in the context of nursing practice, and examining professional issues in nursing (Chinn & Kramer, 2008). As one considers which theory may work best in a given situation, one needs to determine the purpose, the concepts, the definitions, the relationships, the structure, and the assumptions of each theory. One also needs to critically reflect on the clarity, simplicity, generality, accessibility and importance of each theory to guide one's choice (Chinn & Kramer).

The theory guiding this pilot study is Margaret Newman's theory of Health as Expanding Consciousness (HEC). The foundation of HEC is a unitary, dynamic worldview, the concept of pattern as the identifier of wholeness, and transformative unfolding as the reflection of the change process (Picard & Jones, 2005). "Consciousness is a unitary pattern of information that is an inclusive connected-ness with the wholeness of the universe and that affords an infinite repertoire of potential action and an unlimited capacity to love" (Newman, 2005, p. 4).

In HEC health is believed to incorporate disease, when it is present, as part of the pattern of the whole. A person is not any less than whole if he or she experiences an illness or disability. That experience of illness or disability is part of the whole pattern of information, or consciousness of that unique person. (Newman, 2005). Pattern recognition is central to understanding the process of health as expanding consciousness. The ability to recognize patterns is an essential part of experiencing life and learning from those experiences in order to transform patterns and enhance health. In the context of nursing, patterns reflect relationships, with self, others, and the environment. It is crucial to understand one's own pattern, but that can only happen in relationship or partnership with others (Newman, 2005).

HEC is an applicable framework from which to consider the concepts of self-care and self-compassion. By increasing one's awareness of self, one is able to develop the skill of pattern recognition within oneself. Once there is awareness of patterns, one can choose to engage in self-care practices to improve overall health and expand one's consciousness. One way to facilitate the evolution of health as expanding consciousness is to develop and practice self-compassion. As a nurse's level of self-compassion increases, the nurse's ability to be fully present in the moment, and in compassionate relationship with patients, is enhanced. When the nurse is able to be fully present and in relationship with a patient, he or she is able to more effectively engage in pattern recognition and facilitate mutual transformation and healing.

Newman's theory of HEC also reflects the core value of nurse self-care as identified by the American Holistic Nurses Association. As part of caring for self,

nurses recognize and honor their individual patterns and participate in the ongoing development of their whole being, or consciousness, in mind, body, and spirit (American Holistic Nurses Association, 2007). Nurses are not able to support healing in their patients if they are not in the process of caring for and healing themselves. While facing the challenges of professional and personal stress, nurses can increase their self-awareness and begin to take better care of themselves. They are able to choose behaviors and actions that support their overall health and wellbeing, strengthen their ability to respond to stress, and support their healing through expanding consciousness.

Chapter 2: Literature Review

Self-Compassion

Self-compassion is a construct made up of three basic concepts. One concept is self-kindness, which is the practice of showing kindness and understanding to oneself rather than harsh self-judgment and self-criticism. Another concept within self-compassion is common humanity, which is the ability to see one's own experiences of life as part of the larger human experience rather than seeing oneself as different or isolated from others. The third concept is mindfulness, which is the practice of holding one's difficult thoughts and feelings in balanced awareness, rather than allowing oneself to over-identify with them (Neff, 2003).

These are mutually distinct aspects of self-compassion but are interrelated and mutually enhance each other. Mindfulness allows for better self-understanding and self-kindness, and prevents the self-centeredness that leads to feelings of isolation, so one feels more connected with others. Self-kindness and common humanity supports further mindfulness through the understanding that all people experience suffering so one can put feelings of suffering in perspective. Self-kindness and common humanity also enhance each other because if one shows kindness to self, there is less judgment of self and therefore fewer feelings of isolation from others (Neff, 2003).

The practice of self-compassion allows one to acknowledge that all human beings are worthy of compassion, including oneself. It also recognizes that suffering, failure, and inadequacies are all part of the human condition, so all people, including oneself, are deserving of kindness, forgiveness, and respect (Neff, 2003). Individuals

who have higher levels of self-compassion may be able to remain optimistic about the future, even in the face of difficulties, and may also experience more positive feelings. Self-compassion is associated with increased positive mood but that is not due to the suppression of negative feelings, rather it is because self-compassionate individuals are able to hold their negative feelings in mindful awareness. Self-compassion may also increase feelings of emotional safety, allowing for more authentic self-reflection (Neff, Rude, & Kirkpatrick, 2007). The construct of self-compassion can be seen as a healthy form of self-acceptance or a supportive attitude towards the self. Practicing self-compassion will likely lead to positive psychological outcomes and greater satisfaction with life, and may reduce the experience of depression, anxiety and stress (Neff et al., 2007).

Self-compassion is not the same as self-esteem. With self-esteem an individual evaluates self-worth based on the comparison of self to others, one relies on the external judgments and standards put forth by society. In contrast, the self-kindness expressed within self-compassion reduces the need for the judgment of self and others, so there no longer needs to be comparison based on external characteristics (Neff, 2003). Self-compassion is not about being self-centered but it enhances feelings of compassion for self and others. Too much emphasis on self-esteem may contribute to self-centeredness and may lead to the habit of viewing others in a more negative light in order to feel better about oneself. This self-absorbed state increases resistance to change and reduces the ability to be willing and able to know oneself clearly, so it becomes hard to identify areas of self that need growth. Self-compassion on the other hand enhances one's ability to reflect accurately on

maladaptive patterns of thought and behavior within oneself, and motivates one to action to further one's wellbeing. Self-compassion is also associated with more emotional balance and lower levels of anxiety (Neff, 2003).

Self-compassion is also different from self-pity. With self-pity one becomes overwhelmed by one's own problems, and loses sight of the problems of others. It leads to over-identification with one's own suffering and creates the perception of disconnection from others. Self-compassion does not allow for over-identification with emotions, but is also not about avoiding or repressing emotions. Instead it creates space where one can step back with mindfulness and see the broader human context of one's feelings and experiences without distortion or disconnection (Neff, 2003).

Theory

Margaret Newman (2008) speaks of a unitary transformative paradigm that is emerging in the field of health care. There is a slow but increasingly powerful move away from the diagnosis and treatment of diseases and symptoms in isolation, to a more holistic focus on whole individuals, manifesting patterns that reflect aspects of disease and health (Newman, 2008). It is also a shift from seeing illness and disease as strictly negative events to seeing them as patterns of information about the whole person (Newman, 2008). She describes the paradigm as a time of increasing uncertainty and disorganization in which opportunities abound that lead to individual transformation to a higher level of healing. This shift from an orientation towards problems to one of pattern recognition reflects a higher, more expansive dimension of knowledge, transcending what has gone before (Newman, 2008).

The practice of self-compassion is congruent with this unitary transformative paradigm of health. Within self-compassion is the concept of self-kindness, which reflects the ability to see illness and disease as part of the whole human experience, rather than isolating it out and judging it to be bad or to be a failure. Mindful awareness is also an aspect of self-compassion and reflects the ability to shift one's perspective from needing to remove the problem of disease, or avoid the sense of uncertainty and disorganization, to a broader view of seeing disease as part of the pattern of the whole, and viewing the experience of uncertainty and disorganization as opportunity.

A holistic perspective shows that the whole is not simply made up of parts, but that the whole is reflected in all of its parts, as in a hologram. Every human being is whole. When one harshly judges negatively perceived aspects of oneself, and believes one is separate and isolated from others, it appears to be an unconscious attempt to reject one's own wholeness, and this way of thinking comes from a place of limited vision. One can't actually limit one's wholeness, one can only limit one's perception of self. With increased awareness of self, and an increase in the practice of self-compassion, one can begin to experience that wholeness and connectedness to others. What seemed to feel incongruent, out of place, or in conflict, will begin to feel more in balance as one's awareness of wholeness of self, and one's own patterns, is expanded.

The patterns of the whole is what gives dynamic direction to the development of different parts, and these various aspects of the whole must constantly be moving and transforming to support the expanding consciousness. This expansion of

consciousness reflects a deepening of meaning (Newman, 2008). Organisms must change in order to continue to be fully themselves. This dynamic movement enables individuals to grow and change by encouraging self-reflection and a deeper understanding of their particular circumstances (Newman, 2008). The practice of self-compassion engages this dynamic process and allows one to see oneself, one's patterns, more clearly. With increased self-awareness, one can more easily identify areas needing change and can more readily step into action to create that change.

Newman (2008) points out that burnout, and one could infer compassion fatigue as well, occurs when there is an unresolved dissonance in the relationship between the nurse's own value structure and expectations and the values and expectations encountered in the workplace. If one can't let go of old patterns that don't fit, one is not able to create space in which to find new, more effective patterns that move one through to a higher level of understanding and healing. From the point of view of self-compassion, this would be seen as the ability to step back, take stock and practice mindful awareness of one's own values and expectations, and to identify the external values and expectations in the workplace. From this vantage point, one can recognize the patterns in each area and determine what is needed to either find congruence or move through to a new place.

Newman (2008) states that HEC doesn't directly address nurses' examining their own patterns in isolation, but instead it requires that the nurse needs to get in touch with his or her own pattern in relation to the interaction with the patterns of another person. Newman (2008) believes that one needs to be an interactive

participant in the context of relationship with a mentor, colleague, or a patient, in order to see patterns. One also needs to be open to new or different perspectives.

Self-compassion requires that one be fully present with self, which is facilitated through continuous self-reflection and increased self-awareness. This presence with self is needed in order to see all aspects of oneself with clarity and without unnecessary judgment, and to see how one's experiences are similar to and interconnected with common humanity. But one cannot reflect on self in isolation. One really only exists in relationship to another. The aspect of interconnectedness within this new paradigm reflects the primacy of relationship; every person is a center within the complex web of connections (Newman, 2008).

Self-Compassion Research

A number of studies have been done on self-compassion with various groups, often with populations of college students, but have not been done with nurses. Neff, Kirkpatrick, and Rude (2007) did two studies that looked at the relationship of self-compassion to psychological health. In the first study 91 undergraduate students completed a series of self reporting measures related to psychological health. The results showed that self-compassion helped to buffer against anxiety in a stressful setting and also was linked to feelings of connectedness with others. The second study was done with a participant group of 40 undergraduate students, who filled out the Self-Compassion Scale as well as some other psychological outcome measures before and after going through an exercise to learn conflict resolution. The study indicated the level of self-compassion in the group increased after receiving some training in an effective problem solving technique (Neff, Kirkpatrick et al., 2007).

A pair of studies were done to look at self-compassion, achievement goals and perceived academic failure in a group of undergraduate students. The first was done with a group of 222 students who filled out a questionnaire that contained the Self-Compassion Scale as well as tools that measured achievement goals, fear of failure, perceived competency for learning, intrinsic motivation and anxiety. Results of the study showed that those students with higher self-compassion scores had less fear of failure and greater perceived competence (Neff, Hsieh, & Dejittherat, 2005). The second study, with a group of 110 college students, looked at self-compassion and achievement goals measured shortly after the experience of a perceived academic failure. The results showed that self-compassion had a positive association with emotion-focused coping strategies and a negative association with avoidance-oriented coping strategies (Neff et al., 2005). The researchers concluded that self-compassion enhances the learning process by helping to reduce the amount of self-criticism and over-identification with feelings of failure, as well as reduce levels of anxiety and increase the likelihood of adopting positive coping strategies in difficult times (Neff et al., 2005).

Another study was done with 177 undergraduate students that examined the relationship of self-compassion to positive psychological health and the five factor model of personality. A questionnaire was used that included the Self-Compassion Scale and a number of other tools that measured wisdom, personal initiative, curiosity and exploration, happiness, optimism, positive and negative affect, and personality characteristics (Neff, Rude, & Kirkpatrick, 2007). The researchers found that self-compassion was positively associated with happiness, optimism, positive affect,

wisdom, personal initiative, curiosity and exploration, agreeableness, extroversion, and conscientiousness. Self-compassion was also negatively associated with negative affect and neuroticism. They also found that "self-compassion predicted significant variance in positive psychological health beyond that attributable to personality" (Neff, Rude et al., 2007, p. 908). The researchers concluded that self-compassion not only reduces psychopathology, but also is a predictor of psychological strengths (Neff, Rude et al.).

Neff and Vonk (2009) conducted two studies looking at the differences between self-compassion and self-esteem. One participant group was made up of people with a wide variety of ages and occupations who filled out a number of different psychological measurement tools over an eight month period. The other study used a group of undergraduate students, who filled out a one time questionnaire that contained all these same measurement tools. The results from the two studies suggest that self-compassion is linked to many of the benefits typically attributed to high self-esteem in terms of positive emotions, while protecting from the ego defensiveness sometimes associated with the pursuit of high self-esteem. Self-compassion was positively associated with a more stable sense of self worth than self-esteem, and self-compassion was more strongly negatively associated with social comparison, self-evaluative anxiety, anger, and closed-mindedness than self-esteem (Neff & Vonk, 2009).

Mindfulness, Emotional Intelligence, and Resilience Research

As mentioned previously, self-compassion has not yet been studied in a group of nurses, but other concepts that are related to self-compassion have been studied in

groups of nurses and health care professionals. These include mindfulness, emotional intelligence and resilience. Cohen-Katz, Wiley, Capuano, Baker, and Shapiro (2005) conducted a study on the effects of mindfulness-based stress reduction on nurse stress and burnout. They sent two separate randomly assigned cohorts of nurses consecutively through the Mindfulness-Based Stress Reduction (MBSR) training. The results showed that after received the training, nurses had significant reductions in emotional exhaustion and depersonalization, two aspects of the phenomenon of burnout.

A study was conducted to look at the effects of mindfulness-based stress reduction on the mental health of therapists in training. The study included 55 participants who were randomly assigned to the treatment group, who received MBSR training, or the control group. The results showed that those in the MBSR group, in comparison to the control group, showed more significant decreases in perceived stress, negative affect, anxiety, and rumination, and more significant increased in positive affect and self-compassion (Shapiro, Brown, & Biegel, 2007).

Shapiro, Astin, Bishop, and Cordova, (2005) studied the effects of MBSR training on health care professionals using a randomized trial. Those who participated in the MBSR intervention reported decreased perceived psychological stress and job burnout, and greater self-compassion and satisfaction with life, more so than the control group.

Codier, Kooker, and Shoultz (2008) conducted a study to measure the emotional intelligence of clinical staff nurses. The participants included 36 RNs from

three urban hospitals. The results showed positive correlations between clinical performance and emotional intelligence scores.

McCallin and Bamford (2007) examined how emotional intelligence influenced an interdisciplinary care team. They interviewed and observed 44 health care professionals. While emotional intelligence is often considered in the context of an individual, their study showed that emotional intelligence had a positive impact on the effectiveness of a group of individuals in an interdisciplinary care team.

Montes-Berges and Augusto (2007) studied a group of 119 nursing students, using five different psychosocial measurement scales. The results showed that there was a positive correlation between perceived emotional intelligence and higher scores in coping, social support and mental health.

Edward (2005) did a study using in-depth interviews of six mental health clinicians in Melbourne, Australia to examine the phenomenon of resilience. The descriptions of resilience that emerged were having a sense of self, expertise, confidence, flexibility and creativity. Resilience was also seen as being connected with having a sense of faith, the ability to advocate for others and demonstrating empathy and client-centered care.

Hodges et al. (2008) studied the nature of professional resilience in new baccalaureate-prepared nurses in acute care settings. They used focus groups and semi-structured interviews. Themes that emerged reflecting the development of resilience included learning the culture, learning the clinical skill sets, sensing discrepancies and finding reconciliation, acknowledging turning points and adopting street smarts.

Tugade and Fredrickson (2004) tested their hypothesis that resilient people use positive emotions to rebound from negative emotional experiences. Their results showed that the experience of resilience contributed in part to the participants' abilities to achieve efficient emotional regulation, demonstrated by accelerated cardiovascular recovery from negative emotional arousal and by finding meaning in negative circumstances.

Oncology Nurses

Oncology nurses are continuously challenged with a variety of difficult issues in their daily practice. These often include providing complex treatments, handling oncologic emergencies, working with many patients who are experiencing significant pain and suffering, witnessing multiple patient deaths over time, intense family dynamics, ethical and moral dilemmas, issues around death and dying (Abendroth & Flannery, 2006; McMullen, 2007; Aycock & Boyle, 2009). Also included are negative self-thoughts, inadequate resources, organizational issues, and stress with physicians and coworkers (Medland, Howard-Ruben, & Whitaker, 2004). While all areas of oncology nursing are stressful, inpatient oncology nurses may have issues that make them particularly vulnerable to the negative impacts of stress (Medland et al., 2004). Escot, Artero, Gandubert, Boulenger, and Ritchie (2001) note that

> the responsibility of nursing staff in oncology units involves the management of complex, interacting pathologies with a poor prognosis, the administration of treatment with adverse side-effects to patients commonly in pain, mutilated and afraid. Additionally small errors in patient management in this group may have catastrophic consequences. Certain features of the disease are perceived

> as being particularly anxiety-provoking to both patient and professional caregiver; notably the communication of the diagnosis and prognosis, perception of patient mood and everyday functioning, pain and suffering, and the administration of painful, debilitating and disfiguring treatments (p. 273-274).

This high level of work stress and emotional distress is persistent and oncology nurses have limited opportunities to process and debrief challenging situations before having to move on to other patients. Most oncology nurses are not adequately prepared to cope effectively with these experiences. Aycock and Boyle (2009) state "the foundation of cancer nursing is grounded on a platform of workplace-generated emotional adversity. This emanates from multiple expectations that include providing highly effective emotional care to patients and families in the absence of formal education-fostering knowledge and skills to do this" (p.189).

When workplace stress is persistent and unresolved, it can eventually lead to burnout and compassion fatigue, which can impair a nurse's ability to provide quality patient care and maintain healthy personal and professional relationships (Abendroth & Flannery, 2006; McMullen, 2007). Burnout is a phenomenon of three primary characteristics, identified as emotional exhaustion, cynicism, and feelings of inefficacy (Maslach, 2003). It gradually develops over time. Compassion fatigue has a more acute onset and results from the combination of physical, emotional and spiritual exhaustion, caused by the continuous expression of empathy for others (McMullen, 2007). Aycock and Boyle (2009) state that oncology nurses who experience feelings of isolation, lack of appreciation, and being overloaded with work

have a higher incidence of compassion fatigue, especially if they have little awareness of the impact of their work on their emotional health.

Oncology Nurses, Stress, and Burnout

A study was done of hospital oncology nurses in France to examine stress levels. The results showed that stress was primarily related to inadequate training and a lack of time to deal with the psychological component of caring, especially with the terminally ill (Escot et al., 2001). Another study that looked at burnout among oncology care providers showed that emotional job demands were a significant predictor of burnout, especially for care providers who were more susceptible to emotional contagion and therefore at higher risk for burnout (Le Blanc, Bakker, Peeters, Van Heesch, & Schaufeli 2001). Campos de Carvalho, Muller, Bachion de Carvalho, and De Souza (2005) interviewed oncology nurses about causes of work stress and found that common stressors included organizational issues, care restrictions, and relationships among the staff.

A study conducted with oncology nurses in Italy found high levels of emotional exhaustion, and determined that common causes of stress included poor organization and management of the workplace and the perception of greater ambiguity and less control. The researchers concluded that individual coping strategies may be important buffers of perceived stress (Quattrin, Zanini, Nascig, Calligaris, & Brusaferro, 2006). Delvaux, Razavi, Marchal, Bredart, Farvacques, and Slachmuylder (2004) also found that learning positive coping skills was beneficial for managing stress. They examined the effects of a psychological training program on the attitudes, communication skills, and occupational stress on oncology nurses. They

randomized the nurses to a control group and a group that received education and experiential opportunities around stress, communication, coping and other psychosocial issues in oncology care. They found that the nurses in the experimental group experienced a positive change in stress levels and attitudes.

Oncology Nurses and Compassion Fatigue

Abendroth and Flannery (2006) studied the risk of compassion fatigue among hospice nurses, whose work is very similar to that of oncology nurses in regards to the emotional intensity, ethical and moral issues, and difficult family dynamics. They found that over 75% had moderate to high risk of compassion fatigue and 26% were in the high risk category. They determined that trauma, anxiety, life demands and excessive empathy were key determinants in predicting the risk of compassion fatigue. Knowing these variables may help identify nurses at risk and allow for preventative measures to occur to maintaining optimum nursing care (Abendroth & Flannery).

Aycock and Boyle (2009) studied the availability to nurses of three different interventions to manage compassion fatigue. These included on-site professional resources, educational programs, and specialized retreats. Using a survey of oncology nurses working in several different organizations, they found that resource availability varied from 0 to 60%. Seventeen percent of worksites offered no resources and 50 to 60% had pastoral care or employee assistance programs available. Forty-five percent of worksites offered no education or training regarding workplace related coping skills, and over 80% offered no off site retreats.

McMullen (2007) also found that support for nurses' wellbeing was lacking. A study was done to look at compassion fatigue among oncology nurses at a community hospital. The preliminary results showed that in general oncology nurses are ignorant of the term and symptoms of compassion fatigue, and health care organizations are not adequately supporting the psychological wellbeing of staff to prevent the development of compassion fatigue.

Perry (2008) did a phenomenological study to determine why exemplary (as described by their colleagues) oncology nurses seem to avoid compassion fatigue. She found three main themes emerge from the interviews. These were *moments of connection*, or the ability to connect and empathize with patients and families, *making moments matter*, which is the ability to appreciate the significant moments in the nurse-patient relationship, and *energizing moments*, where nurses manifest a sense of humor, playfulness, positive attitude, self confidence, self awareness and zest for life. Perry found that the common link among these three themes is attitude, which is defined as a complex mental state involving beliefs, feelings and values, and dispositions to act in certain ways.

Chapter 3: Methodology

Research in nursing involves a systematic search for knowledge about issues important to the nursing profession (Polit & Hungler, 1995). Research is one of four aspects of the field of nursing that are interrelated and interdependent, the other three being theory, education, and practice (Macnee & McCabe, 2008). Nursing research is important for a number of reasons. It is necessary to support the evolution and advancement of professionalism, to define and communicate the social relevance of the profession of nursing, to maintain accountability for standards of care, and guide decision-making in nursing practice (Polit & Hungler).

A significant amount of nursing research, like research in many other fields, is based on the use of the scientific method. The scientific approach to inquiry includes the use of a set of orderly, logical procedures that guide the investigation into the hypothesis or question of interest. The purpose of the scientific approach may include description, exploration, explanation, and prediction and control of the information being gathered (Polit & Hungler, 1995). There are two main types of scientific research, basic and applied. Basic research is intended to accumulate information or to formulate or refine a theory. Applied research is focused on finding a solution to an immediate problem (Polit & Hungler).

While the scientific method of inquiry provides a strong, effective way to gather information or to solve problems, it does have its limitations. It is not possible to definitively prove or disprove a hypothesis with a single study. Often studies need to be repeated a number of times to verify the results. Another limitation relates to the moral or ethical questions that come up around research on living organisms, there is

a need to balance what is acceptable in the pursuit of science with the consideration of the rights of the subjects. Human complexity is another challenge in scientific research. Every human being has a unique combination of personal and social environments, mental abilities, values and beliefs and life-style choices that complicate attempts to accurately gather information. While physiological functioning is generally able to be measured accurately, it is much more difficult to accurately collect data about intangible or abstract psychological factors. It is also difficult to control for a multitude of confounding variables in an attempt to effectively study those variables under investigation (Polit & Hungler, 1995).

Nursing research, like that in other fields, involves several major steps. Initially the researcher enters the conceptual phase where the research question is formulated, the literature is reviewed, and a theoretical framework is developed. The next phase is that of designing and planning the research study. This involves selecting a research design, identifying the population and the sampling plan, and determining specific methods of data collection. The researcher then enters the empirical phase where the data is collected and prepared for analysis. Once the analysis and interpretation of data is completed, the results are then disseminated (Polit & Hungler, 1995). The research process for this pilot study is presented in detail later in this chapter.

There are two main categories of research methodology, quantitative methods and qualitative methods. Quantitative research is a systematic process and occurs under controlled conditions. It involves collecting objective numerical information using formal instruments. The information, or data, is then statistically analyzed and

interpreted. Qualitative research is also a systematic process, but it involves the collection of subjective, narrative information, with little researcher-imposed control. The intention of qualitative research is to focus on the understanding of the whole of a phenomenon, and to allow for the subject's interpretation and meaning of the phenomenon, rather than the interpretation of the researcher (Polit & Hungler, 1995). Both forms of methodology are equally important in nursing research, and are effective when used in the appropriate situation.

The choice of a qualitative or quantitative research method in a study should be determined by the type of question that is being asked. The question posed in this pilot study is "how do oncology nurses perceive self-compassion?" A quantitative methodology was used to collect data to begin to address this question. Quantitative research methods are considered more traditional, and include a variety of forms of experiments, surveys, and correlational studies, as well as other lesser known quantitative strategies (Knapp, 1998). For this pilot study a valid, reliable survey tool was chosen that measured the concept of self-compassion.

Nursing research includes studies of physical variables that primarily use quantitative methodology, as well as studies of abstract concepts that are psycho-social, emotional or spiritual in nature, referred to as social research, which can be done with either quantitative or qualitative methodology. Knapp (1998) states that approximately 25 percent of nursing research is physical and 75 percent would be considered social research. In social research there are three primary ways of measuring variables, which are asking, observing, and reading records. Most of the quantitative nursing research that would be considered social research uses asking

tools to gather information. The most common form of asking used in nursing research is the printed questionnaire. It is an easy way to collect data but may suffer from various problems, including non-response. In cases where asking would not be possible or appropriate, observation methods are used. Reading records is primarily used when secondary analysis of data is being done (Knapp).

Asking instruments usually consist of "several items for which individual item scores are obtained, with those scores subsequently summed or averaged to produce subscale scores and/or total scores" (Knapp, 1998). Asking devices can be very formal and standardized tools, or consist of unstructured interview questions. Three common standardized asking devices include visual analogue scales, which ask individuals to indicate a response by putting a mark on a scale ranging from 0 to 100, semantic differential scales, where individuals are asked to rate various concepts on a scale with seven options, and Likert-type scales, which usually have five ordinal response options ranging from strongly disagree to strongly agree (Knapp).

This pilot study used a survey tool for collecting data. This quantitative methodology was chosen for this study as it allowed for a simple, effective way to measure the concept of self-compassion as perceived by the individuals participating in the study. The asking tool used in this pilot study is a survey that contains the Self-Compassion Scale which is a Likert-type scale.

Procedure

Approval of the Institutional Review Boards, at Abbott Northwestern Hospital and Augsburg College, was obtained prior to data collection. This approval indicated that the protocol for this pilot study maintained the ethical and responsible treatment

of human subjects during research. Because this pilot study posed minimal risk to participants, it was eligible for expedited review based on criteria set forth by Federal Policy 46.110, specifically because it was research on characteristics of individuals, such as studies of perception, where the investigator does not manipulate subjects' behavior and the research would not involve stress to the subjects (Augsburg College Institutional Review Board Information Form, 2008).

The potential participants were initially notified about the pilot study through verbal information provided by the primary investigator to the unit based nursing council. This was followed by fliers (see Appendix A) that were posted in various areas of the nursing unit and pilot study packets that were placed in the mailboxes of each nurse by the primary investigator. Participants were given three weeks to complete and return the surveys to the primary investigator. Once the surveys were returned, a research assistant worked with the primary investigator to analyze the data collected by the survey and to determine the final results of the pilot study.

The pilot study packet that was distributed to each potential participant included a letter of consent (see Appendix B), a demographic information sheet (see Appendix C) and the Self-Compassion Scale (see Appendix D). The letter of consent provided a detailed description of the pilot study, assured confidentiality and anonymity of all returned surveys, and provided contact information for the participants if they had further questions or concerns about the pilot study. The demographic information sheet contained questions about participant's age range, level of education in nursing, the number of years of experience in nursing in general, and number of years of experience specifically in oncology nursing.

Participants

Potential participants were selected from a convenience sample. A convenience sample includes members of the population who can be easily found and are convenient for the researcher to recruit (Macnee & McCabe, 2008). It is a method that is easy, quick and inexpensive to use. If the research is at an early stage, and the ability to generalize the results is not an issue, then it can be an appropriate way to obtain participants (Singleton & Straits, 1999). The disadvantage of such a sample is that it will likely not be very diverse and cannot provide that opportunity to generalize results to other groups (Macnee & McCabe).

Because this project was a pilot study, the intention was to keep it relatively small, simple, and inexpensive in order to fit the scope of this integrative thesis. One way to do this was to use a convenience sample of nurses on one particular unit to participate in the study. Oncology nurses are especially challenged to demonstrate compassion to individuals who are suffering from painful and debilitating illness and their families who struggle to support their loved ones. These patients and families are often facing the very real prospect of death from their disease. When the work of the nurses requires significant levels of compassion extended towards others, one wonders if they feel the same amount of compassion towards themselves. The unique demands of oncology nursing can often contribute to increased perceptions of stress and difficulty coping with the challenges of work. With this in mind, the oncology nurses at a large urban teaching hospital were chosen to be in the prospective pool of participants.

To be eligible for participation, the potential subjects needed to be Registered Nurses (RNs) who were regularly scheduled to work on E 3000, the inpatient hematology/oncology unit, at Abbott Northwestern Hospital. At the time of the study there were 54 RNs regularly scheduled to work on this unit. Participation was completely voluntary. Those wishing to participate were asked to complete a survey that included a demographic information sheet and the Self-Compassion Scale. Consent was implied by the return of the surveys.

Survey Tool

The methodology used in this pilot study used a survey tool which included the Self-Compassion Scale. A scale is a set of written statements that measures a specified variable (Macnee & McCabe, 2008). In this case the variable in question is the self-reported measurement of self-compassion. The Self-Compassion Scale was developed by Kristin D. Neff to examine the construct of self-compassion (Neff, 2003). It is a Likert-type scale using a range of scores from 1, which is "almost never" to 5, which is "almost always". Participants are asked to rate 26 different statements on this scale of 1 to 5. Because the purpose of this pilot study was to examine how oncology nurses perceived self-compassion, this scale is an appropriate instrument to employ in the research process, as it is designed to specifically measure the variable of self-compassion as reported by an individual about himself or herself. This scale was chosen as the method of research as it was a valid and reliable tool with which to measure the specific variable being studied, and was available for use with permission from the author (see Appendix E).

The construct of self-compassion is defined as the combination of the practice of self-kindness, the perception of oneself as part of common humanity, and the practice of mindfulness, or balanced awareness of thoughts and feelings (Neff, 2003). According to Neff (2003) the Self-Compassion Scale was designed to measure the three main components of self-compassion on six separate subscales. The six subscales are paired up as follows: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. The mean scores for each subscale are calculated by reverse coding responses to the negatively worded items comprising the self-judgment, isolation, and over-identification subscales, then calculating the mean scores for all six subscales, and finally summing the means to create a total self-compassion score. Neff (2003) states

> The inclusion of subscales in the measure was theoretically motivated, so that the constituent components of self-compassion would be reflected in the scale design. However, the subscales were expected to be highly inter-correlated, and the main object of the scale was to measure self-compassion as a single overarching construct (p. 226).

Four demographic questions were also included, which asked individuals to provide information about their age, their level of education in nursing, the number of years of experience they have in nursing in general, and years specifically in oncology nursing. These were included to see if there was any correlation between the measurement of self-compassion and these four independent variables.

Reliability and Validity

Reliability reflects the internal consistency of the scale to measure similar and related items (Macnee & McCabe, 2008). Abstract concepts, like the concept of self-compassion being examined in this pilot study, are often measured using scales consisting of several items that all relate to the same aspect that is being studied (Macnee & McCabe). If all the items on the scale do relate to the same aspect, there is then an expectation that there is a consistent pattern in how participants would respond to the items (Macnee & McCabe).

Validity reflects how accurately the scale yields information about the real variable being studied. Content validity asks if the content of the scale, in this case the construct of self-compassion, is appropriate and complete (Macnee & McCabe, 2008). Another form of validity is criterion-related validity. This asks if the results from the scale relate to a known criterion that is relevant to the variable. A third type of validity is construct validity, a broader question that includes the measures of content and criteria-related validity. Construct validity reflects the extent to which an instrument measures what it is supposed to measure (Macnee & McCabe).

Evidence for the validity and reliability of the Self-Compassion Scale was demonstrated through a series of studies done by Neff (2003). The results of these studies indicated that self-compassion is significantly correlated with positive mental health outcomes such as lower levels of depression and anxiety and greater life satisfaction (Neff, 2003). The validity of the Self-Compassion Scale was determined through calculation of correlation coefficients between the Self-Compassion Scale and eight other scales measuring similar constructs, including

> the short form of the Marlowe-Crowne Social Desirability scale developed by Strahan and Gerbasi (1972)…the self-criticism subscale of Blatt, D'Afflitti and Quinlan's (1976) Depressive Experiences Questionnaire… the Social Connectedness Scale (Lee & Robbins, 1995)… the Trait Meta-Mood Scale (Salovey, Mayer, Goldman, Turvey, & Palfai, 1995)…the Almost Perfect Scale – Revised (Slaney, Mobley, Trippi, Ashby, & Johnson, 1996)…the Speilberger State-Trait Anxiety Inventory-Trait form (Speilberger, Gorsuch, & Lushene, 1970)…the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961)…and the Diener's Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985)… (Neff, 2003, pp. 292-230).

Confirmatory factor analysis was used on each of the six subscales to determine whether a one factor model or a two factor model would fit more appropriately, and to determine the appropriate loadings for each of the 26 items on the Self-Compassion Scale. Internal consistency reliability for the self-kindness subscale was 0.78 and for the self-judgment scale it was 0.77 (Neff, 2003). The internal consistency reliability for the common humanity subscale was .80 and for the isolation subscale it was 0.79 (Neff, 2003). The internal consistency reliability for the mindfulness subscale was 0.75 and was 0.81 for the over-identification subscale (Neff, 2003). An overall model confirmatory factor analysis was also done to assess the fit of the six inter-correlated factors to the 26 items (Neff, 2003). Finally another confirmatory factor analysis was done to "determine if a single higher-order factor of self-compassion would be able to explain the inter-correlations between the six

factors" (Neff, 2003, p. 232). It was found that the internal consistency reliability for the 26 item Self-Compassion Scale was 0.92 (Neff, 2003).

Limitations

By using the Self-Compassion Scale, the primary investigator hoped to begin to explore how oncology nurses would perceive compassion towards themselves. Because the Self-Compassion Scale is a valid and reliable measure, one would infer that the findings from it would be accurate. Being a survey tool, it does have limitations in its usefulness. One potential problem in using this scale is that the data is obtained through self report, which could be affected by the intentional or unintentional bias of the participants who fill out the scale. Another limitation of this tool is that while the content being measured is considered qualitative and subjective, the tool itself is a quantitative measurement. It creates a limit on the amount and quality of information provided by the participants about self-compassion because it does not include any open ended questions or allow for participant comments.

Chapter 4: Findings

This chapter includes a report of the results presented in statistical form and a description of the procedure used for data analysis. The study findings are discussed from the perspective of the primary investigator, the theoretical perspective of Newman, and from the perspective of a holistic nursing framework. Additional discussion includes the significance of the findings for oncology nurses and nursing leadership. Limitations of the study are described and the needs for further research are identified.

A total of 37 surveys were returned during the study period of three weeks, reflecting a 68.5% response rate. Of the returned surveys, 35 were completely filled out, two were missing data. One participant did not answer the question of years in nursing, and another participant did not answer the question of years in oncology nursing. The data analysis was carried out by a statistician assisting the primary investigator in this pilot study.

Demographics

The questions included in the demographic section of the survey included age range, level of education in nursing, years in nursing, and years in oncology nursing. Approximately half the respondents were between 20 and 39 years of age, and the other half were between 40 and 69 years of age. The vast majority, just over 78%, had Bachelor's degrees in nursing. Just over half of respondents had worked in nursing for less than ten years, and just over two thirds of the respondents had worked for less than ten years specifically in oncology nursing. See Table 1 for details about the demographic results (see also Appendix F).

TABLE 1: Demographic Information

	N	%
Age		
20-29	13	35.14
30-39	6	16.22
40-49	5	13.51
50-59	11	29.73
60-69	2	5.41
Education		
Associate Degree	7	18.92
Baccalaureate Degree	29	78.38
Diploma	1	2.70
Years in Nursing		
0-4	12	32.43
5-9	8	21.62
10-14	3	8.11
15-19	3	8.11
20-24	1	2.70
25-29	4	10.81
30-35	4	10.81
>35	1	2.70
missing	1	2.70
Years in Oncology Nursing		
0-4	16	43.24
5-9	10	27.03
15-19	3	8.11
20-24	4	10.81
25-29	1	2.70
30-35	2	5.41
missing	1	2.70

Self-Compassion Scale

The Self-Compassion Scale was designed to measure the three main components of self-compassion on six separate subscales. The six subscales are paired up as follows: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. The mean scores for each subscale are calculated by reverse coding responses to the negatively worded items comprising the self-judgment, isolation, and over-identification subscales, then calculating the mean scores for all six subscales, and finally summing the means to create a total self-compassion score (Neff, 2003). See Table 2 for the summary of mean score results from the Self-Compassion Scale (see also Appendix G).

The mean is a set of scores computed by adding up all the scores and dividing by result by the number of scores. The mean scores for each subscale, for the group as a whole, indicate that the group generally demonstrates slightly more self-kindness than self-judgment, slightly more common humanity than isolation, and slightly more mindfulness than over-identification. Scatter plot diagrams of the results of each subscale item, as it relates to each demographic variable, can be viewed in Appendix I. The group's overall mean score on self-compassion falls very close to the middle of the scale, at 2.98, with a standard deviation of 0.54. Standard deviation measures how far a single score is from the center of the distribution (Welkowitz, Ewen, & Cohen, 1991). The individual mean self-compassion scores ranged from a low of 1.9 to a high of 3.95.

TABLE 2: Summary of mean self-compassion scores for the participant group

(Scale range is 1 to 5, with 1 being "almost never" and 5 being "almost always")

Subscale	**Mean**	**Standard deviation**
Self-Kindness	3.44	0.71
Self-Judgment	2.68	0.83
Common Humanity	3.50	0.76
Isolation	2.51	0.90
Mindfulness	3.75	0.61
Over-identified	2.63	0.79
Total mean	2.98	0.54

Analysis

A correlation analysis was done to examine potential relationships between the four demographic variables and the six subscales on the Self-Compassion Scale. Spearman's correlation coefficient (r) is a non-parametric measure of correlation. It can vary from -1 (perfect negative relationship) to 1 (perfect positive relationship). The analysis was done to test the null hypothesis that in the population represented in this sample, the correlation between the two variables is 0 (no relationship). The strength of a correlation coefficient increases as follows: 0.0 to 0.2 indicates very weak to negligible correlation, 0.2 to 0.4 indicates weak, low correlation, 0.4 to 0.7 indicates moderate correlation, 0.7 to 0.9 indicates strong, high correlation, and 0.9 to 1.0 indicates very strong correlation.

The analysis showed that there were two areas that had statistically significant correlation. The common humanity subscale was found to be weakly positively correlated with years in nursing (Spearman's $r=0.37$, $p=0.026$) and years in oncology nursing (Spearman's $r=0.36$, $p=0.0297$). Noted along with the r values (correlation) are the corresponding p values (probability). Though the correlation coefficients descriptively fall within the "weak, low correlation" range, both these correlations have p values that are within $p < 0.05$, and therefore warrant further attention within any replication or adaptation of this work. In light of the small sample size of this preliminary study, any replication into these areas with larger more statistically representative samples may prove to add relevant findings. A discussion of these correlations of the demographic variables of years in nursing and years in oncology

nursing with the common humanity subscale is presented later in this chapter. Table 3 shows details of the correlation analysis (see also Appendix H).

TABLE 3: Correlation Coefficient Analysis

Spearman Correlation Coefficients Prob > |r| under H0: Rho=0				
	Age	**Education**	**Years in nursing**	**Years in oncology nursing**
Self-Kindness	0.18 p=0.29	-0.19 p=0.26	0.026 p=0.88	0.077 p=0.65
Self-Judgment	-0.027 p=0.87	0.045 p=0.79	0.0027 p=0.99	-0.022 p=0.90
Common Humanity	0.22 p=0.19	-0.12 p=0.49	0.37 p=0.026	0.36 p=0.0297
Isolation	0.027 p=0.88	0.067 p=0.69	-0.039 p=0.82	-0.19 p=0.26
Mindfulness	0.18 p=0.29	-0.014 p=0.94	0.19 p=0.28	0.26 p=0.12
Over-identified	-0.10 p=0.55	0.066 p=0.69	0.039 p=0.82	0.025 p=0.89
Total mean self-compassion score	0.11 p=0.51	-0.14 p=0.41	0.083 p=0.63	0.19 p=0.28

Discussion

While most of the correlation analysis of the data did not reveal statistically significant correlations among variables, two statistically significant correlations were revealed. It appears that there is a weakly positive relationship between feelings of common humanity and the length of time working in nursing, and also specifically oncology nursing. The common humanity concept, as it relates to the over-arching construct of self-compassion, refers to the ability to see one's personal experience in light of the common human experience (Neff, 2004). Rather than feeling separated and isolated from those around, one is able to shift one's perspective to see that one's suffering is part of the shared experience of being human, that others feel the same way and have the same kinds of experiences. The results indicate that the longer one works in nursing, and also specifically oncology nursing, the more likely one is to consider oneself as a part of the shared experience of common humanity.

As someone accumulates experience in nursing practice, he or she will likely develop a stronger sense of feeling connected to others around them in his or her professional and personal life. He or she will have had experiences of suffering and difficulty in his or her own life, and he or she will have seen the suffering and difficulties in the lives of others around him or her. Especially in oncology nursing one encounters significant amounts of physical, emotional, and spiritual suffering experienced by patients and their families as they face life threatening illnesses. As he or she continues to develop expertise and maturity in his or her nursing practice, he or she will have repeated opportunities to provide compassionate care to cancer patients and families. With this accumulation of oncology nursing experience, the

nurse is more likely to become aware that his or her own experience of suffering appears very similar to the suffering of others, even if it is not related to a personal experience of cancer. As he or she provides compassionate care for others who are suffering, he or she will more likely be able to acknowledge his or her own need for compassionate care, and will provide that for himself or herself as well.

The fact that there weren't significant correlations of nursing experience, or oncology nursing experience, with any other subscale items or total self-compassion scores indicates that having more nursing experience, and specifically oncology nursing experience, doesn't necessarily lead to a higher overall level of self-compassion. And the fact that the overall mean score for self-compassion for the group lies in the middle of the scale indicates that just being a nurse doesn't mean one will have more compassion for oneself, even though many nurses demonstrate significant compassion to others. There are likely additional personal and professional variables that contribute more to increased self-compassion than simply working as a nurse. Further research is needed to help identify what those variables are and how they can be cultivated in order to increase self-compassion to support the healing of individual nurses, as well as healing within the profession of nursing.

According to Neff (2003) the practice of self-compassion implies that when possible, one should try to prevent suffering before it occurs through proactive behaviors that promote wellbeing. Self-compassion facilitates effective self-regulation and adaptive emotional expression and optimizes psychological functioning. It reflects a balance between concern for self and concern for others, recognizing that compassion towards oneself is necessary to prevent disconnection

from others (Neff, 2003). Demonstrating self-compassion facilitates the process of caring for self, body, mind, and spirit, through activities and interventions that reduce stress, increase coping skills and support the balance of personal and professional life.

While self-compassion is beneficial on an individual level, it may also benefit society in general, as the more it is demonstrated by individuals the more it may contribute to a culture shift that values compassion for self, and lead to "a kinder, less self-absorbed, less isolated and more emotionally functional populace"(Neff, 2003, p. 94). This potential for societal benefit can be applied to the nursing profession as well. Self-compassion is beneficial for nurses individually, but would also contribute to the healing process of the nursing profession as a whole. Nurses who are self-compassionate would be better able to work together, support each other, and mentor new graduate nurses effectively. They may also demonstrate an enhanced ability to communicate and collaborate with physicians and other care providers.

Increased self-compassion among nurses may also help address one of the other chronic challenges for the nursing profession, the sense of nursing as being inferior in some way, which leads to feelings of separateness and being "different" from other professions. When nurses become more self-compassionate, it may lead to a shift in this chronic pattern to a place where nurses are better able to recognize their positive interconnectedness with other fields of study and practice, and their place within the shared human experience.

The results of the study indicate that there is a weak positive relationship between years of experience in nursing, and oncology nursing, and the ability to feel and express interconnectedness with others, and see one's own life experiences as

part of the overall experience of common humanity. The process of gaining knowledge and experience in one's nursing work reflects the process of expanding consciousness as discussed by Newman (2008). In the unitary transformative paradigm of health as expanding consciousness patterns develop and emerge that reflect one's knowledge and experience as an evolving whole. In this evolutionary process, which occurs within the context of relationship with others, one begins to discover meaning in one's work and life. This accumulation and deepening of meaning reflects the expansion of consciousness, and allows for the recognition of one's own patterns (Newman, 2008). The recognition of one's own patterns will help one gain insight into areas of self that need attention, and what actions may be beneficial to meet those needs.

The aspect of common humanity, as seen as part of the practice of self-compassion, is expressed as part of one's pattern of health. As one gains more experience in nursing, one increases one's awareness of one's own patterns. As one recognizes one's own patterns, one is more able to recognize the patterns of others, and will be able to acknowledge and experience the feeling of interconnectedness as part of the experience of common humanity.

New graduate nurses require adequate clinical and psycho-social mentorship and guidance as they work towards developing their oncology nursing skills and expertise. They are particularly vulnerable to the multiple stressors they will invariably encounter as they begin to build their nursing experience (Medland et al., 2004). Their student-mentor relationship, with colleagues who are more experienced in oncology nursing, is critical to whether they learn to effectively manage the

ongoing stress of the work, and how successful they are in establishing work and home life balance. It will also contribute to their ability, or lack of ability, to care for themselves, body, mind and spirit. All of these factors are part of the nurses' own patterns of health.

The results of the study reflect the benefit of increased years of nursing experience on a nurse's ability to feel the interconnectedness with others, and to feel that one's own suffering or distress is not unique but is part of the shared human experience. This experience of connection with others will contribute to the nurse's overall wellbeing, and his or her ability to handle stress, maintain balance and care for self.

The goal of nursing, according to Newman (2008), is to provide a transforming presence for those in need of nursing care. She states that once a nurse experiences the shift into the unitary transformative paradigm of health as expanding consciousness, it will be a strong foundation for daily nursing practice. She identifies that a crucial part of the new paradigm is that the nature of consciousness requires the presence of another person who can acknowledge one's own being (Newman, 2008). Newman states that the self has no meaning outside the context of relationship. The essence of being human is found in the experience of community and unity with another. This concept is also expressed by Neff (2004) who states

> The process of self-compassion…requires that you step outside yourself to give yourself kindness and see your experience as part of the larger human experience. This means you are taking the position of the "other" towards yourself, thus breaking the cycle of over-identification. This more objective

> stance allows you to put your personal experiences into greater perspective (especially when you compare your own situation to those of others who are far worse off), so that the extent of your suffering is seen with greater balance and clarity (Neff, 2004, p.24).

One only knows oneself in the context of relationship with another. This is the only way to be able to recognize one's own patterns, and the patterns of others. Therefore, by practicing self-compassion, one is able to step back and reflect on self as if one is actually another person looking in. By doing this, one can more readily recognize patterns, and therefore identify possible actions for change, growth and transformation, to promote the expansion of consciousness.

The overall mean score of self-compassion, of the group as a whole, was 2.98, on a scale of 1 to 5, with 1 being the low end of scale and 5 being the high end of scale. This indicates there is ample opportunity for increasing the experience and practice of self-compassion to enhance self-care, and support the healing process for the individual nurse, as well as for the nursing profession. Self-care is one of the core values of nursing practice as identified by the American Holistic Nurses' Association. This core value states that "holistic nurses engage in holistic self-assessment, self-care, and personal development, aware of being instruments of healing to better serve self and others" (American Holistic Nurses' Association, 2007, p.106). The American Holistic Nurses' Association (2007) also states that

> Holistic nurses honor their unique patterns and the development of the body, the psychological-sociological-cultural self, the intellectual self, and the spiritual self. Nurses cannot facilitate healing unless they are in the process of

> healing themselves. Through continuing education, practice and self-work, holistic nurses develop the skills of authentic and deep self-reflection and introspection to understand themselves and their journey. It is seen as a lifelong process (p. 17).

Holistic nurses must then be actively engaged in the process of pattern recognition for self and others, and participate fully in the unitary transformative paradigm of health as expanding consciousness. In order for nurses to be able to be fully present and provide compassionate care for others, they must practice that same presence and compassion with themselves. In order to create a healing environment for others, they need to begin by creating a healing environment within themselves. They need to care for themselves, body, mind, and spirit as a necessary part of their overall professional nursing practice.

Significance for Oncology Nurses

The experience of workplace stress will increase the risk for nurses of developing burnout or compassion fatigue, and this problem is exacerbated when nurses do not care for themselves (Abendroth & Flannery, 2006). Often nurses are not aware of the warning signs of burnout or compassion fatigue and also may not have the self-awareness necessary for recognizing when they are at risk. Too often nurses neglect or ignore their own emotional needs while they are caring for others. Medland et al. (2004) point out that the challenges of oncology nursing, including witnessing the suffering, pain and intense emotional experiences of patients and families, require that the needs of caregivers, as well as patients, are addressed in order to maintain optimum care and a healthy work environment. "Nurses need to

strive for the moral maturity of honoring their own need to be regarded compassionately" (Medland et al., 2004, p. 49).

Oncology nurses benefit from integrating self-care practices into their daily lives to support their overall wellbeing and avoid the risk of burnout or compassion fatigue. These practices may include learning more effective coping strategies and stress management techniques (Delvaux et al., 2004). They may also include individual or social activities that help them renew their physical, emotional, and spiritual energy, and create a buffer from continuous exposure to perceived stress (Quattrin et al., 2006). Finding balance in one's life is critical for survival as an oncology nurse, and it's important for the nurse to reconnect with what brought him or her into nursing (Aycock & Boyle, 2009). The practice of self-compassion can enhance a nurse's ability to create and maintain balance in life, to develop and maintain healthy personal and professional relationships and to strengthen the ability to handle stress and face challenges in an effective manner.

Significance for Nursing Leaders

"The optimal care of others begins by ensuring that the needs of the caregiver are met" (Medland et al., 2004, p. 50). Leaders in nursing and healthcare organizations must appreciate the significant levels of stress experienced by oncology nurses and be knowledgeable about the accompanying risk for burnout and compassion fatigue (Medland et al., 2004; Aycock and Boyle 2009; Quattrin et al., 2006). "In the absence of deliberative attention to the need for interventions that address compassion fatigue, ideal holistic oncology nurse functioning will remain compromised" (Aycock & Boyle, 2001, p. 190). There needs to be recognition that

the affective dimension of oncology nursing care is just as important as the increasingly sophisticated pharmacological and technical dimensions of care provided by oncology nurses (Medland et al., 2004; Aycock & Boyle).

There is a critical need for leaders to facilitate care for the caregiver through resources made available in the organization with the intent to promote nurse self-care, reduce or prevent burnout and compassion fatigue, and create a healthy work environment (Abendroth & Flannery, 2006; Quattrin et al., 2006). These resources may include some form of support for psychological and emotional needs as well as bereavement and grief issues (Medland et al., 2004). Training is also needed in self-awareness, positive coping skills, and stress management techniques to increase nurses' ability to handle the stress. Training opportunities may include counseling skills, conflict resolution, and communication skills (Escot et al., 2001; Medland et al., 2004; LeBlanc et al., 2001). Other options include programs to promote positive staff relationships and enhance professional recognition (Medland et al., 2004; LeBlanc et al., 2001; Escot et al., 2001).

The skills involved in the practice of self-compassion can be learned and nurtured through the support of nursing leadership and the maintenance of a healthy work environment. Leadership support may be demonstrated through increasing the availability of authentic opportunities for self-reflection and recognizing the value of self-care as an important aspect of providing high quality nursing care in their organization. A healthy work environment is one in which nurses experience a sense of gratification and fulfillment and passion for their work (Medland et al., 2004). This is needed for the provision of quality patient care, increased staff engagement,

retention of mature, knowledgeable oncology nurses, and effective knowledge and skill development of novice oncology nurses (Abendroth & Flannery, 2006; Aycock & Boyle 2009; Quattrin et al., 2006).

Limitations

One of the limitations of this study is the small number of participants. Expanding the size of the group would have allowed for additional data that would have strengthened the results. Another limitation was only surveying oncology nurses. While oncology nurses do very stressful work, nurses in other clinical areas also experience fairly high levels of stress as well. By studying nurses from various clinical areas, one can explore how the different clinical experiences may affect levels of self-compassion. A third limitation of the study was having only four demographic questions. If additional demographic questions had been asked regarding other aspects of professional and personal life, additional relevant information, about the relationship of those other factors with the practice of self-compassion, may be obtained.

The use of only one measurement tool was also a limitation. By including other relevant tools that reflect other psychological, emotional or spiritual concepts, one would be able to examine the relationship of self-compassion with other aspects of a person's experience of stress, burnout, and compassion fatigue. The use of a strictly quantitative methodology was also a limitation. When exploring subjective concepts and ideas, it would be helpful to also include some open ended questions to collect data that reaches more deeply into the subjective experience of self-compassion, stress, burnout and compassion fatigue.

Conclusion

There is great opportunity for additional research of self-compassion in nursing, as this area of focus, both from the field of nursing as well as the field of psychology, is largely untouched. This pilot study provides an initial step on the journey towards exploring more fully the experience of self-compassion with a population of individuals who are so deeply engaged in compassionate work. Additional studies could be carried out that would include larger numbers of participants, additional areas of clinical experience, and other measurement tools, along with the Self-Compassion Scale, to measure stress, anxiety, spiritual issues, burnout, compassion fatigue, and self-care practices. Other studies might examine the effects of increased self-compassion among nurses on the profession of nursing, specifically in the areas of nursing education, nursing leadership and nursing's role in transforming health care.

The shift towards the unitary, transformative paradigm of health and healing is happening right now, and nurses are on the forefront of this expansion of consciousness. It is more important than ever before to create opportunities for healing for nurses and the nursing profession, through the increased practice of self-compassion as self-care in order to promote the provision of high quality, compassionate care for others.

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Appendix A

Oncology Nurses on E 3000

An invitation to participate in nursing research

"Oncology nurses' perceptions of self compassion: a pilot study"

Conducted by Mimi Lindell, RN, OCN

You will be receiving a study packet in your mailboxes shortly
This packet will contain:
A letter of consent with detailed information about the study
A short survey on self-compassion
Return envelope

The survey is voluntary, it will only take a few minutes of your time to complete, and all results will be kept confidential

Please fill out the survey and return it in the return envelope to:
Mimi Lindell RN, OCN, MR 11404

Please return it by: January 31, 2009
Please contact Mimi at x36238 or Miriam.lindell@allina.com with any questions

Appendix B

Letter of Consent

Oncology nurses' perception of self-compassion: a pilot study

You are invited to participate in a research study which examines the perception of self-compassion by oncology nurses working on an inpatient oncology unit. You were selected as a possible participant because you are an RN who is regularly scheduled to work on the inpatient oncology unit at Abbott Northwestern Hospital. You are being asked to read this form, and ask any questions you may have, before you decide whether or not you would like to participate in the research study.

This research study is being conducted by Mimi Lindell, RN, a nurse clinician with the Institute for Health and Healing at Abbott Northwestern Hospital, as part of the completion requirements for her Master of Arts degree in Nursing at Augsburg College. Her advisor is Magdeline Aagard, associate professor at Augsburg College. Mimi will receive assistance from a data analyst during the research study. This analyst will sign an agreement of confidentiality prior to having access to any research records.

Background information

The purpose of this study is to better understand how oncology nurses perceive compassion towards themselves. Self- compassion may be defined as treating oneself with kindness, recognizing one's shared humanity, and being mindful when considering negative aspects of oneself.

Research subject's bill of rights

People who volunteer to participate in an experiment (also called a research study or clinical trial) need to understand what is expected of them and why the research is being done. As you think about whether or not to volunteer, it is important that you know that you have rights in place to help protect you. These rights, listed below, will be further explained as you read this informed consent document.

If you are asked to participate in a research study, you have the right to:

1. be told the purpose and the details of the research study
2. have the drugs or devices (tools or pieces of equipment) used in the research study described
3. have the procedures of the research study and what is expected of you explained
4. have the risks, dangers, and discomforts of the research study described
5. have the benefits and advantages of the research study described
6. be told of other drugs, devices or procedures (and their risks and benefits) that may be helpful to you
7. be told of medical treatment available to you should you be injured because of the research study
8. have a chance to ask questions about the research study
9. quit the research study at any time without it affecting your future treatment
10. have enough time to decide whether or not to take part in this research study and to make that decision without feeling forced or required to participate

Procedure

If you agree to be in this study, you will be asked to complete a survey which can be completed in about 5-10 minutes. Do not write your name on the survey. If you are uncomfortable with any question, you do not have to answer it. When you are finished with the survey, please place it in the pre-addressed envelope provided, seal the envelope, and return it through the interoffice mail system to Mimi Lindell, RN at MR 11404. If you choose not to take part in this survey, please discard the survey and this letter.

Risks and benefits of being in the study

There are minimal risks associated with this study. You may experience some emotional discomfort while filling out the survey. If you feel you need assistance with managing this emotional discomfort, please call the Allina Employee Assistance Program at 1-800-531-5145. There will not be any direct benefit for you from completing this survey but it is hoped that the results of this research study will contribute to a greater understanding of the self-compassion perceived by oncology nurses.

Costs

There are no costs to you as a participant in this research study.

Confidentiality

The records of this survey will be kept private. Every effort will be made to ensure confidentiality, but anonymity cannot be guaranteed. Surveys are not identified by name. Any sort of report that might be published will not include any information that will make it possible to identify you. The surveys will be stored under lock and key in the researcher's office, and only the researcher and her assistant will have access to them. If the research is terminated for any reason prior to completion of the study, the data will be destroyed. Raw data will be kept till December 31, 2012, and then will be destroyed.

Voluntary nature of the research study

Participation in this survey is voluntary. Your decision whether or not to participate will not affect your current or future relations or employment with Abbott Northwestern Hospital or Augsburg College. If you decide to participate, you are free to not answer any question you choose, and you may discontinue participation at any time without affecting those relationships.

Contacts and questions

The researcher conducting this study is Mimi Lindell, RN. If you have any questions now or later, you are encouraged to contact Mimi at 612-863-6238 or Miriam.lindell@allina.com .

Mimi's advisor is Magdeline Aagard, Associate Professor of Nursing at Augsburg College. She can be contacted at aagard@augsburg.edu; or phone 612-330-1207.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, or if you have any questions about your rights as a research subject, you are encouraged to contact the Allina Institutional Review Board Administrative Office at 612-775-9629.

You may keep this form for your records. By completing the survey, you have indicated your understanding of this research study, and you have given your informed consent to participate in this research study.

Appendix C

Oncology Nurses Perception of Self Compassion: a pilot study

Demographic Sheet

Your age:

20-29_____ 30-39_____ 40-49_____ 50-59_____ 60-69_____

Highest level of education in nursing:

Diploma_____ Associate Degree _____

Bachelor's Degree _____ Master's Degree _____

How many years in nursing:

0-4____ 5-9____ 10-14____ 15-19____ 20-24____

25-29____ 30-35____ more than 35____

How many years in <u>oncology</u> nursing:

0-4____ 5-9____ 10-14____ 15-19____ 20-24____

25-29____ 30-35____ more than 35____

Appendix D

Self-Compassion Scale

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

_____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.

_____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.

_____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.

_____ 5. I try to be loving towards myself when I'm feeling emotional pain.

_____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.

_____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.

_____ 8. When times are really difficult, I tend to be tough on myself.

_____ 9. When something upsets me I try to keep my emotions in balance.

_____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.

_____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____ 14. When something painful happens I try to take a balanced view of the situation.

_____ 15. I try to see my failings as part of the human condition.

_____ 16. When I see aspects of myself that I don't like, I get down on myself.

_____ 17. When I fail at something important to me I try to keep things in perspective.

_____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.

_____ 19. I'm kind to myself when I'm experiencing suffering.

_____ 20. When something upsets me I get carried away with my feelings.

_____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.

_____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.

_____ 23. I'm tolerant of my own flaws and inadequacies.

_____ 24. When something painful happens I tend to blow the incident out of proportion.

_____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.

_____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

Appendix E

To Whom it May Concern:

Please feel free to use the Self-Compassion Scale in your research. You can e-mail me with any questions you may have. I would also ask that you please e-mail me about any results you obtain with the scale, and would appreciate it if you send me a copy of any article published using the scale. The appropriate reference is listed below.

Best,

Kristin Neff, Ph. D.
Associate Professor
Educational Psychology Dept.
University of Texas at Austin
1 University Station, D5800
Austin, TX 78712

e-mail: kristin.neff@mail.utexas.edu
Ph: (512) 471-0382
Fax: (512) 471-1288

Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. *Self and Identity, 2, 223-250.*

Coding Key:
Self-Kindness Items: 5, 12, 19, 23, 26
Self-Judgment Items (reverse scored): 1, 8, 11, 16, 21
Common Humanity Items: 3, 7, 10, 15
Isolation Items (reverse scored): 4, 13, 18, 25
Mindfulness Items: 9, 14, 17, 22
Over-identified Items (reverse scored): 2, 6, 20, 24

To compute a total self-compassion score, take the mean of each subscale, then compute a total mean.

(This method of calculating the total score is slightly different than that used in the article referenced above, in which each subscale was added together. However, I find it is easier to interpret the scores of the total mean is used.)

Letter retrieved from http://www.self-compassion.org/index.html

Appendix F

TABLE 1: Demographic Information

	N	%
Age		
20-29	13	35.14
30-39	6	16.22
40-49	5	13.51
50-59	11	29.73
60-69	2	5.41
Education		
Associate Degree	7	18.92
Baccalaureate Degree	29	78.38
Diploma	1	2.70
Years in Nursing		
0-4	12	32.43
5-9	8	21.62
10-14	3	8.11
15-19	3	8.11
20-24	1	2.70
25-29	4	10.81
30-35	4	10.81
>35	1	2.70
missing	1	2.70
Years in Oncology Nursing		
0-4	16	43.24
5-9	10	27.03
15-19	3	8.11
20-24	4	10.81
25-29	1	2.70
30-35	2	5.41
missing	1	2.70

Appendix G

TABLE 2: Summary of mean self-compassion scores for the participant group

(Scale range is 1 to 5, with 1 being "almost never" and 5 being "almost always")

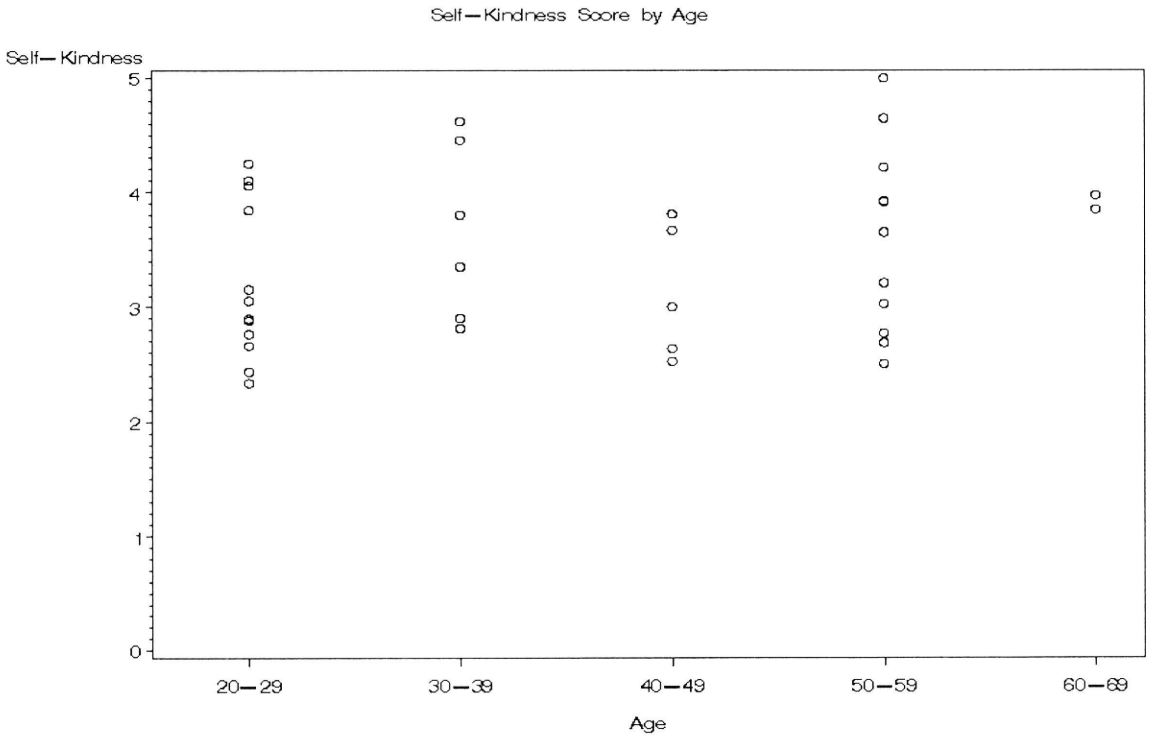
Subscale	**Mean**	**Standard deviation**
Self-Kindness	3.44	0.71
Self-Judgment	2.68	0.83
Common Humanity	3.50	0.76
Isolation	2.51	0.90
Mindfulness	3.75	0.61
Over-identified	2.63	0.79
Total mean	2.98	0.54

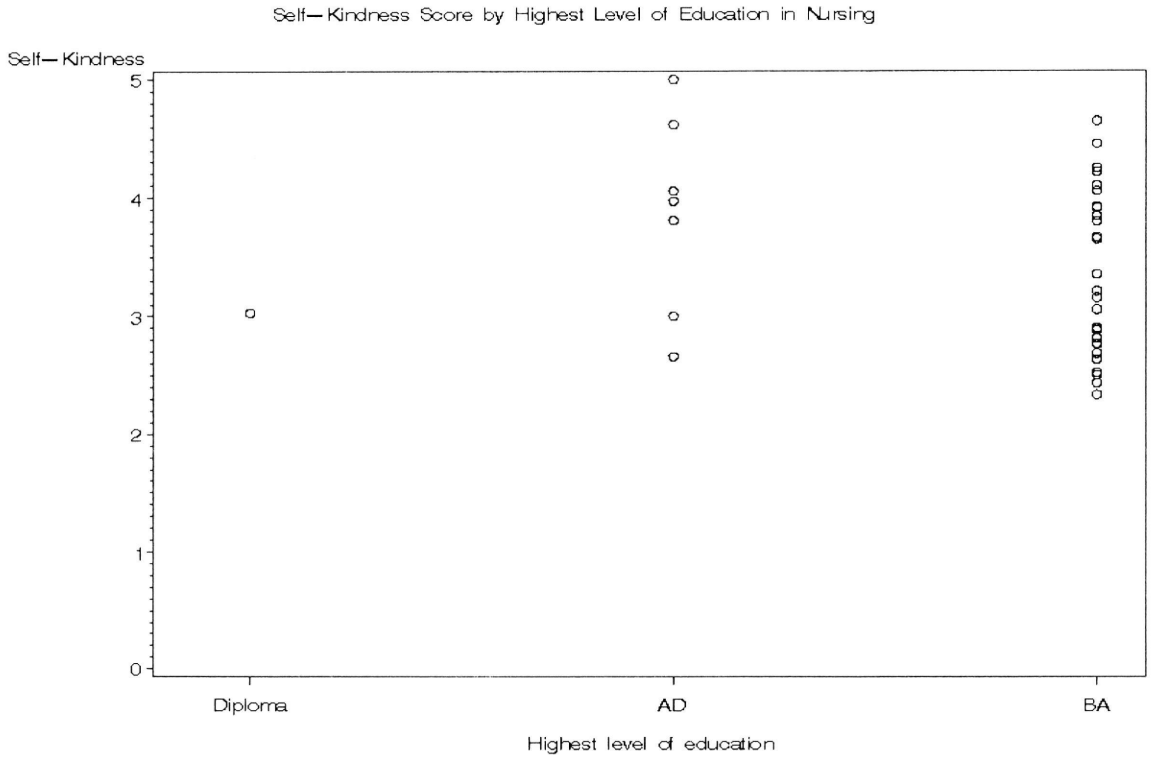
Appendix H

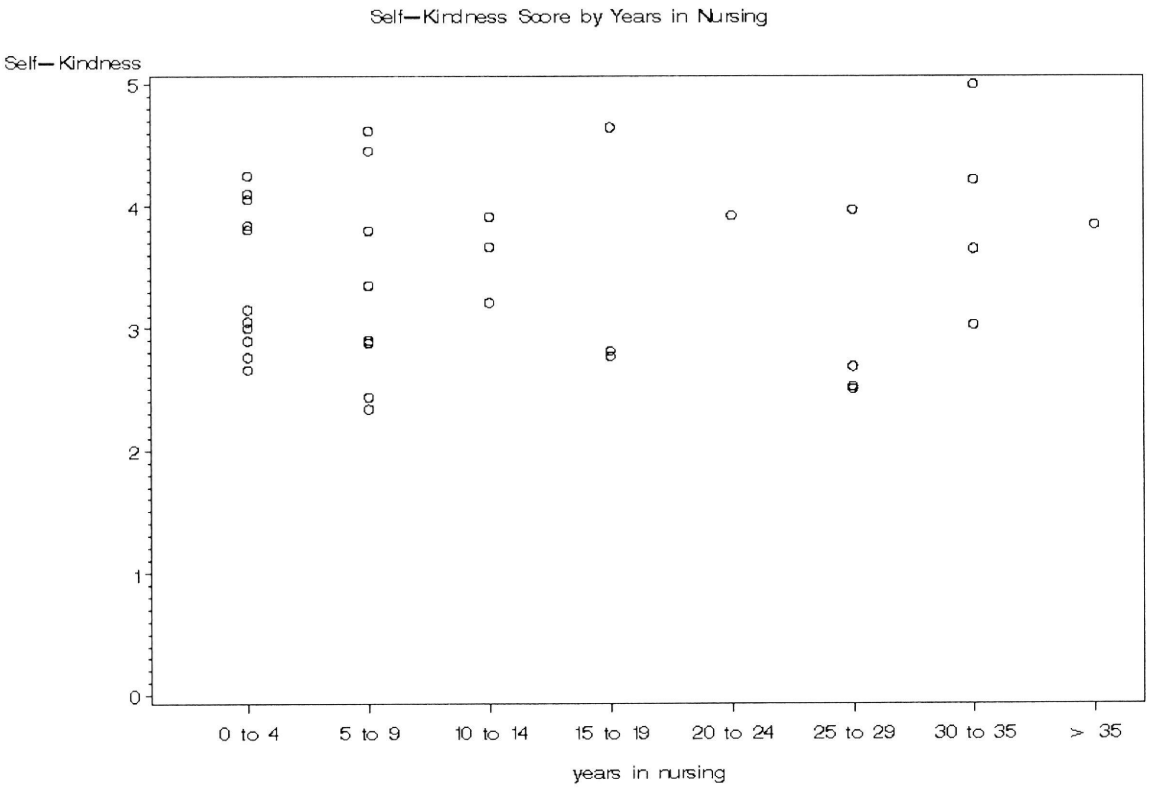
TABLE 3: Correlation Coefficient Analysis

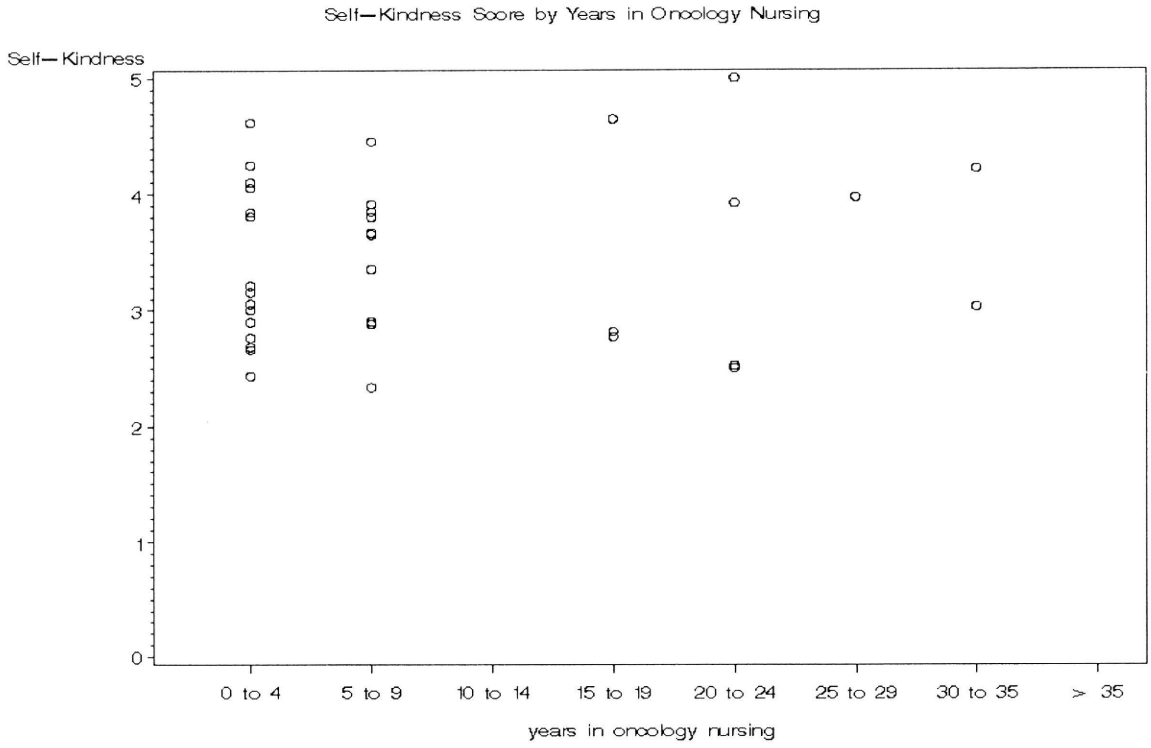
Spearman Correlation Coefficients Prob > |r| under H0: Rho=0				
	Age	**Education**	**Years in nursing**	**Years in oncology nursing**
Self-Kindness	0.18 p=0.29	-0.19 p=0.26	0.026 p=0.88	0.077 p=0.65
Self-Judgment	-0.027 p=0.87	0.045 p=0.79	0.0027 p=0.99	-0.022 p=0.90
Common Humanity	0.22 p=0.19	-0.12 p=0.49	0.37 p=0.026	0.36 p=0.0297
Isolation	0.027 p=0.88	0.067 p=0.69	-0.039 p=0.82	-0.19 p=0.26
Mindfulness	0.18 p=0.29	-0.014 p=0.94	0.19 p=0.28	0.26 p=0.12
Over-identified	-0.10 p=0.55	0.066 p=0.69	0.039 p=0.82	0.025 p=0.89
Total mean self-compassion score	0.11 p=0.51	-0.14 p=0.41	0.083 p=0.63	0.19 p=0.28

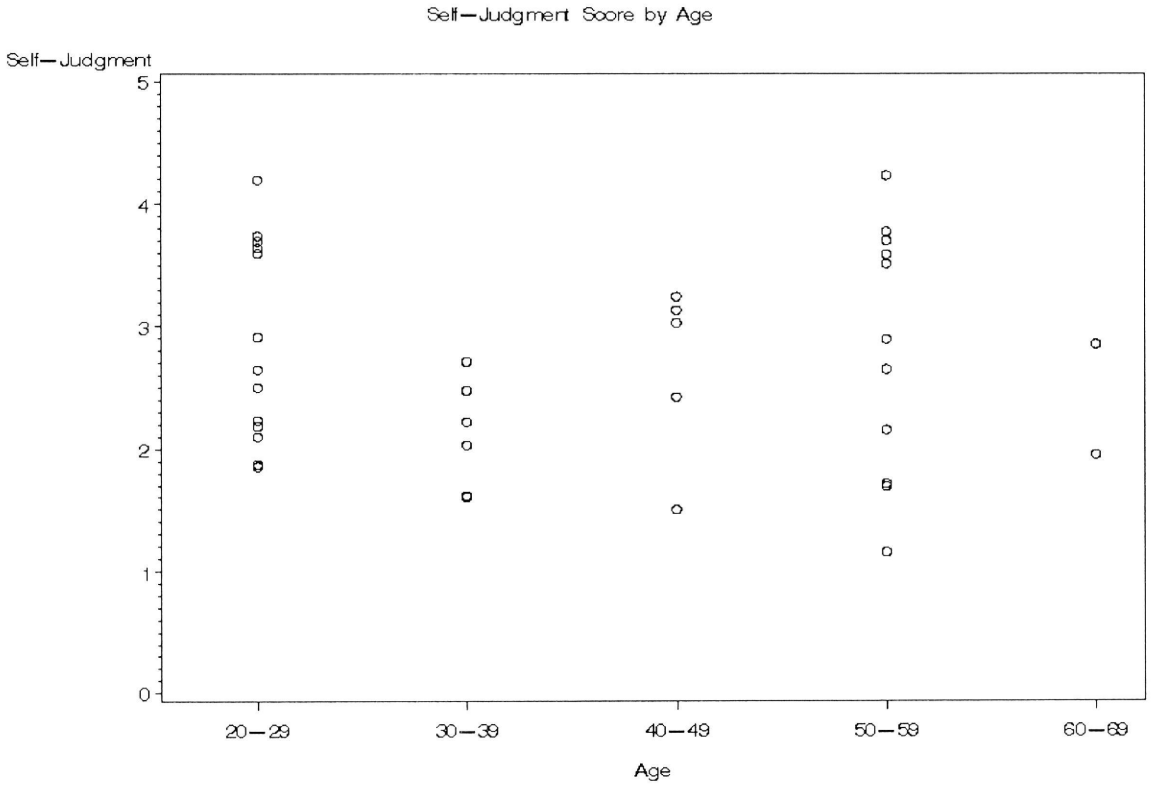
Appendix I


Self—Kindness Score by Age
Self—Kindness
5
4
3
2
1
0
20—29
30—39
40—49
50—59
60—69
Age


Self—Kindness Score by Highest Level of Education in Nursing
Self—Kindness
5
4
3
2
1
0
Diploma
AD
BA
Highest level of education


Self—Kindness Score by Years in Nursing
Self—Kindness
5
4
3
2
1
0
0 to 4
5 to 9
10 to 14
15 to 19
20 to 24
25 to 29
30 to 35
> 35
years in nursing


Self—Kindness Score by Years in Oncology Nursing
Self—Kindness
5
4
3
2
1
0
0 to 4
5 to 9
10 to 14
15 to 19
20 to 24
25 to 29
30 to 35
> 35
years in oncology nursing


Self-Judgment Score by Age
Self-Judgment
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4
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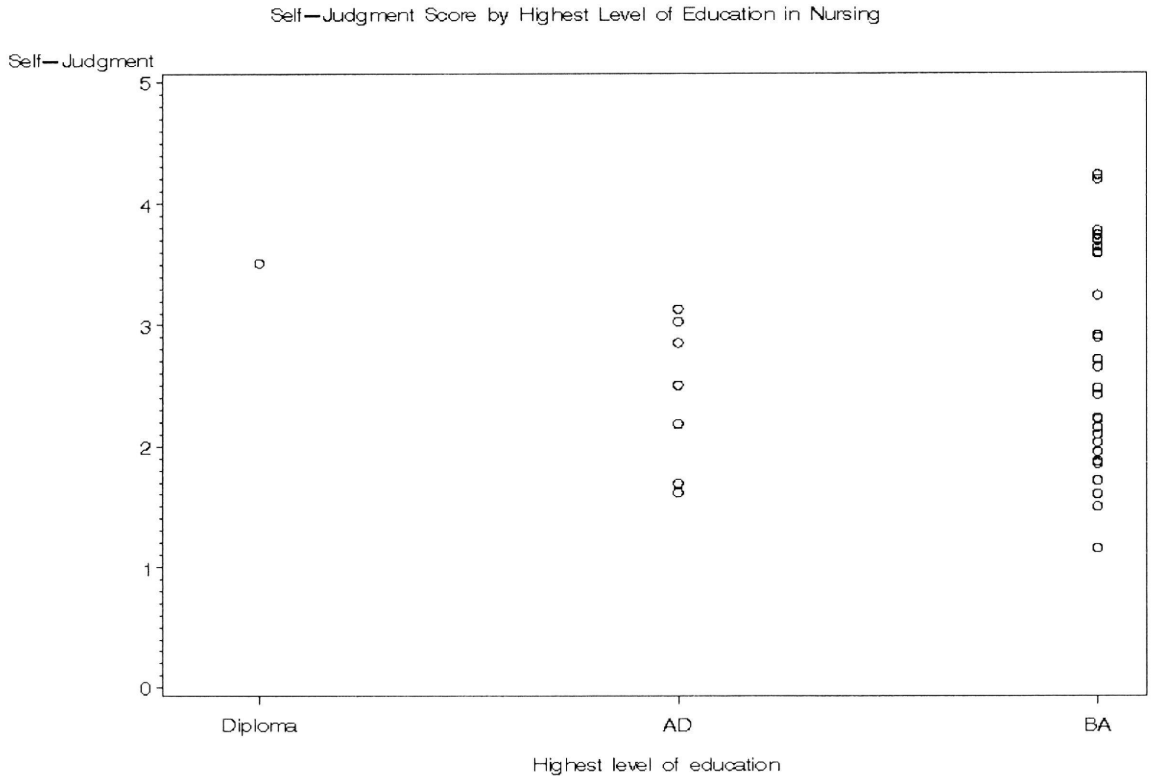
2
1
0
20-29
30-39
40-49
50-59
60-69
Age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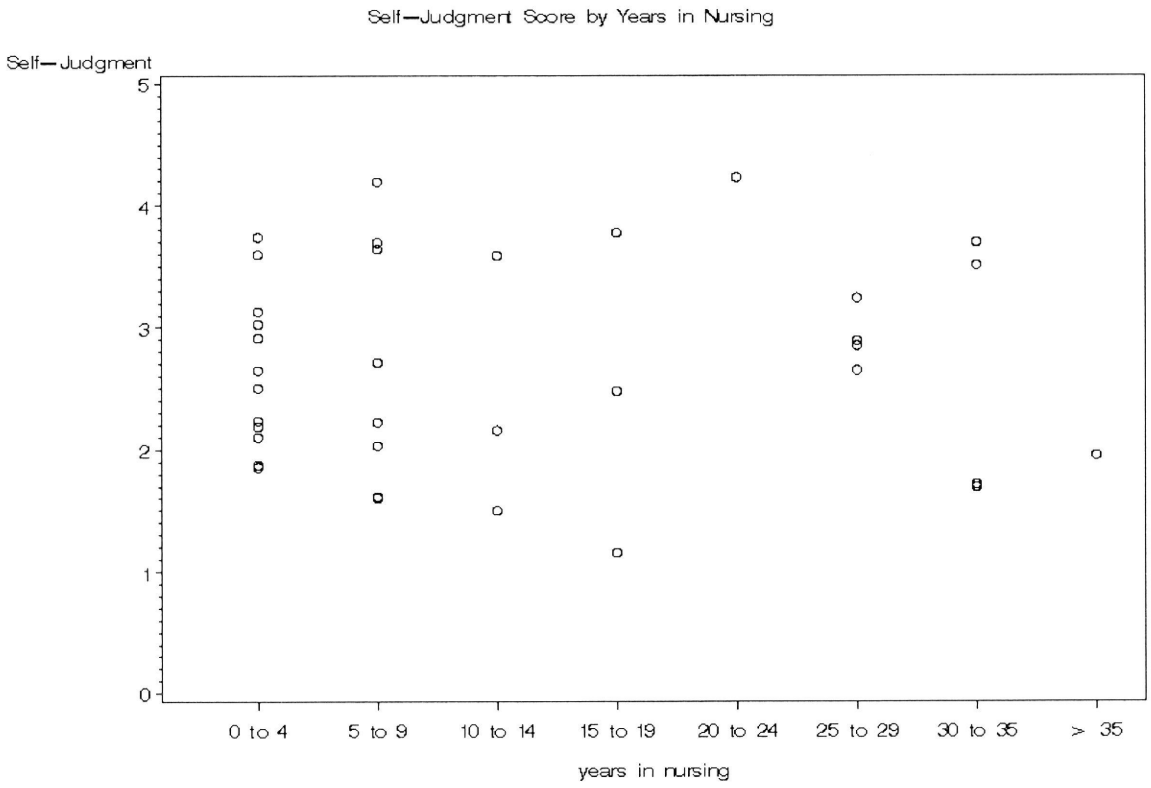
Self-Judgment
5
4
3
2
1
0
Diploma
AD
BA
Highest level of education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Self–Judgment
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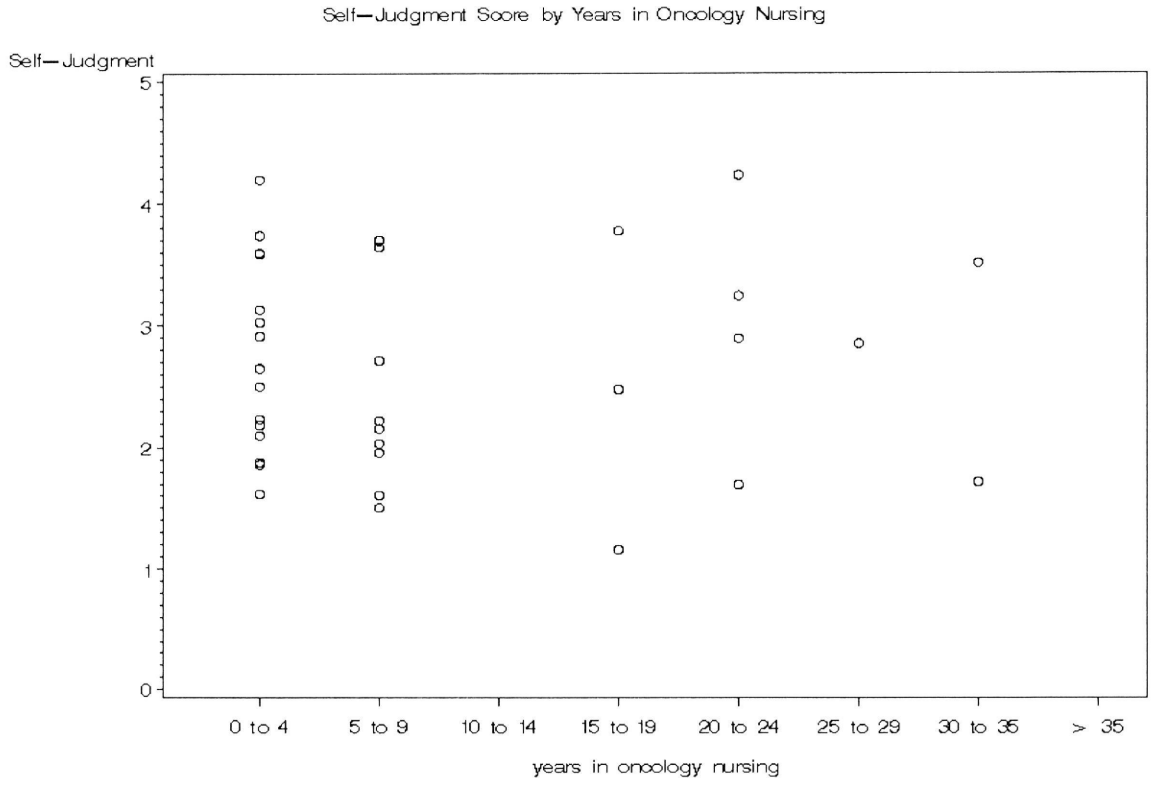
4
3
2
1
0
0 to 4
5 to 9
10 to 14
15 to 19
20 to 24
25 to 29
30 to 35
> 35
years in nursing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Self–Judgment
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2
1
0
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5 to 9
10 to 14
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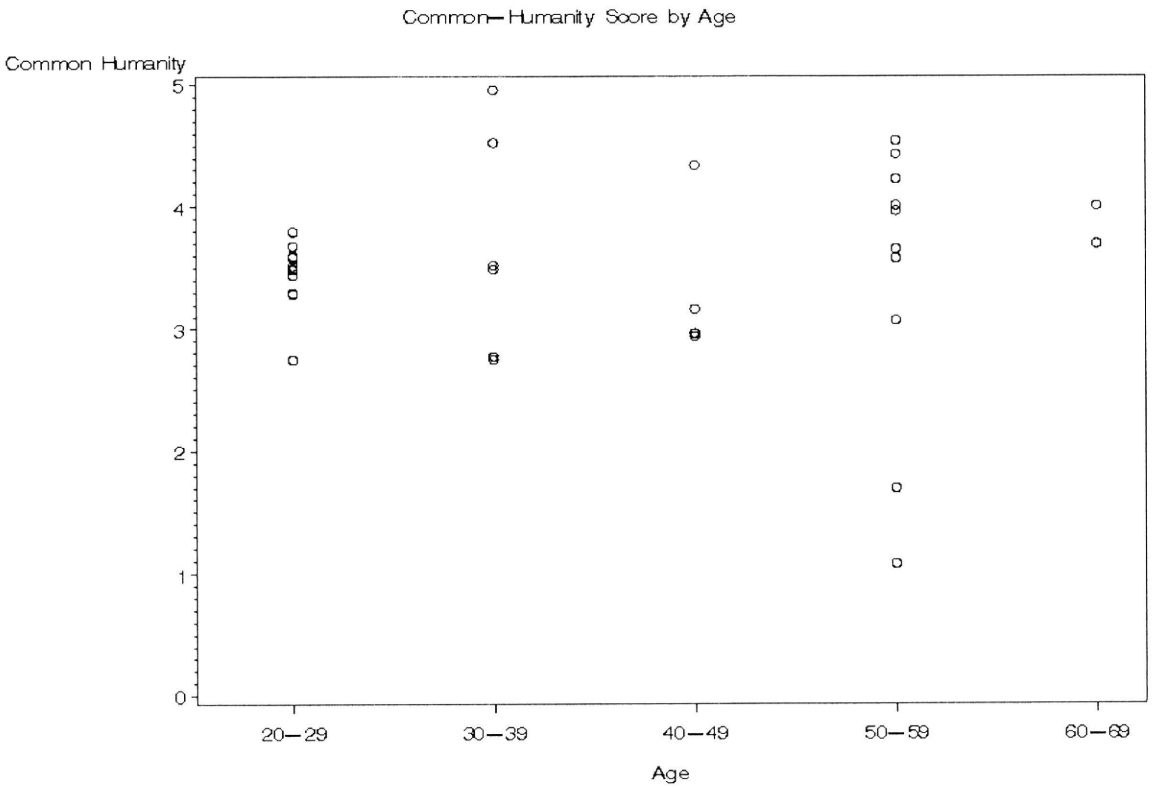
20 to 24
25 to 29
30 to 35
> 35
years in oncology nursing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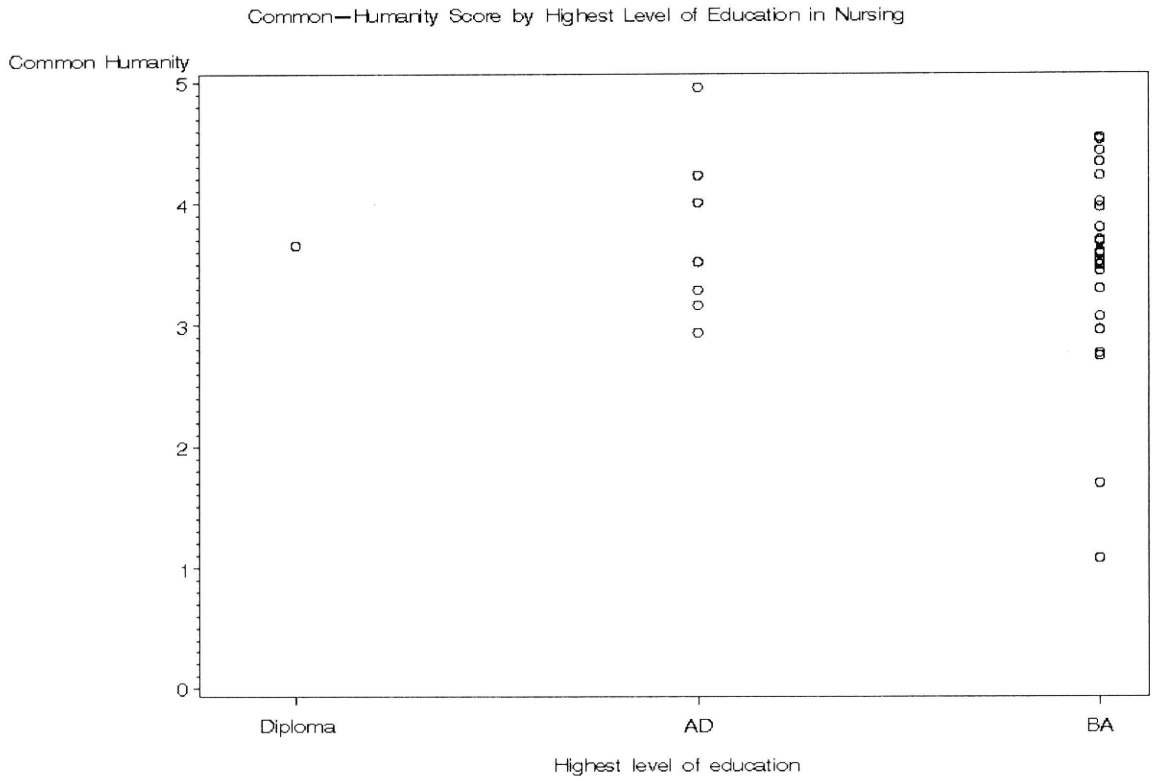
2
1
0
20—29
30—39
40—49
50—59
60—69
Age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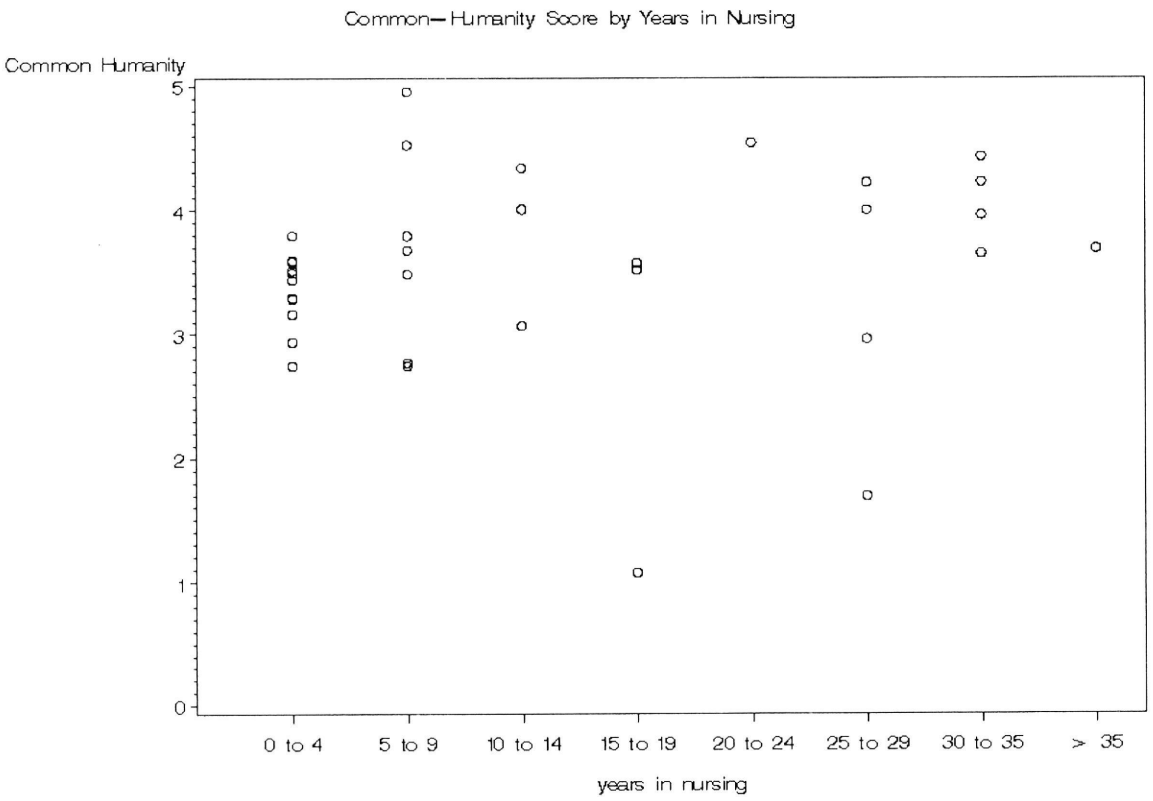
4
3
2
1
0
Diploma
AD
BA
Highest level of education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Common Humanity
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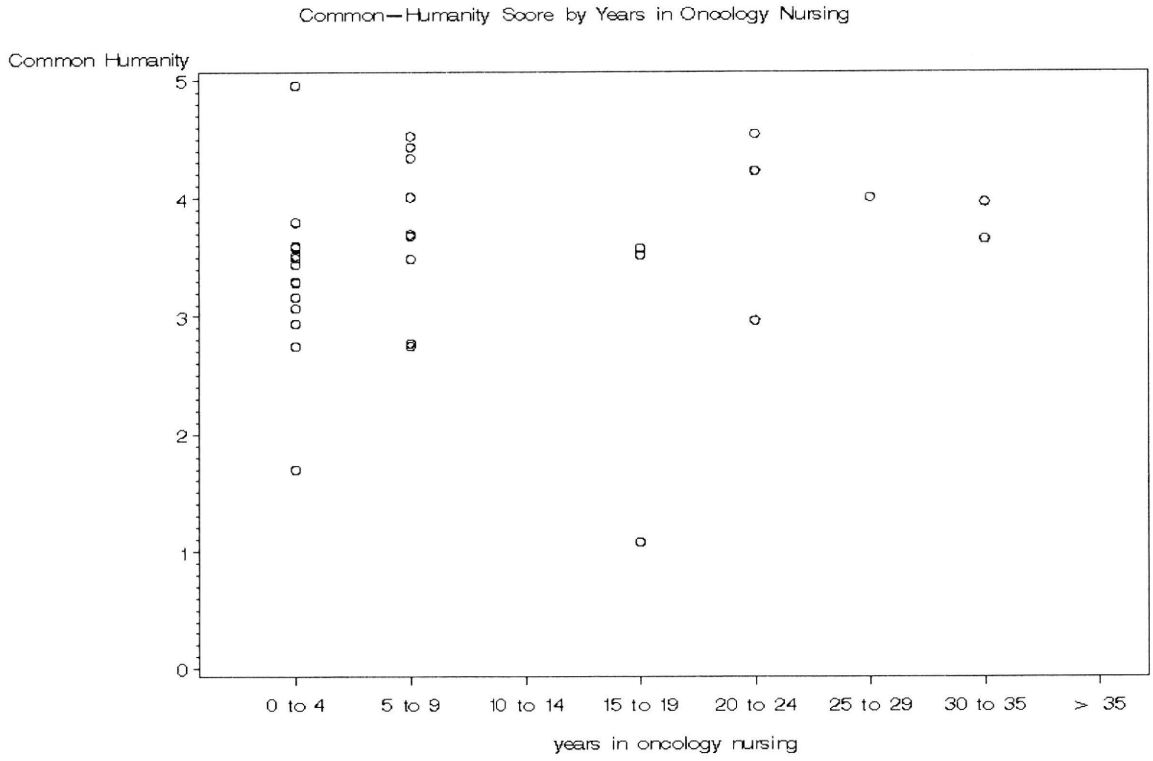
> 35
years in nursing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Common Humanity
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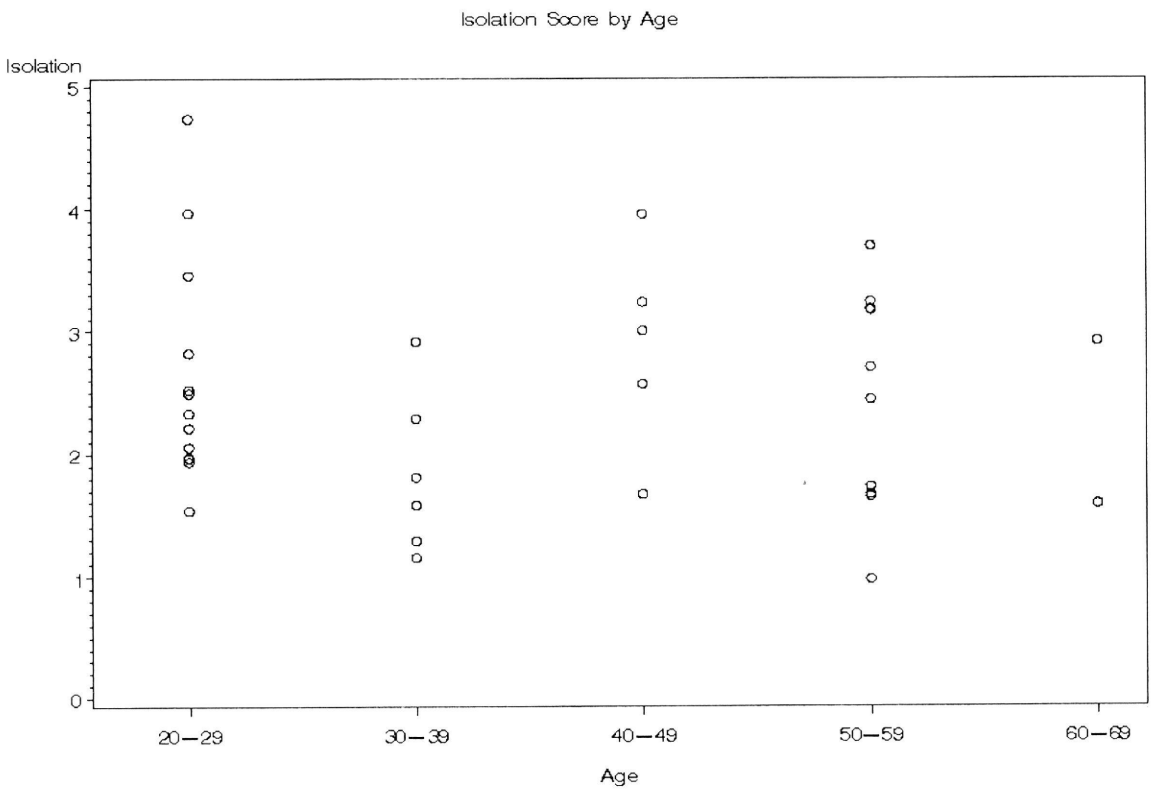
years in oncology nursing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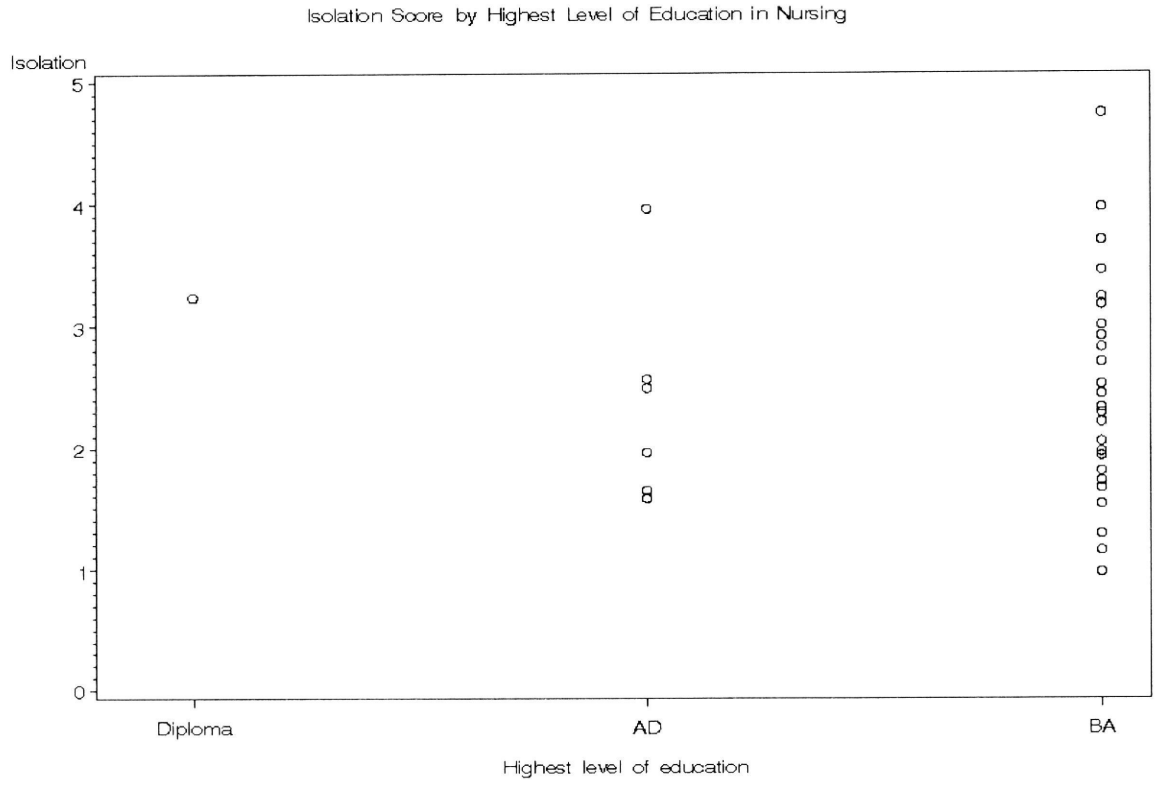
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Diploma
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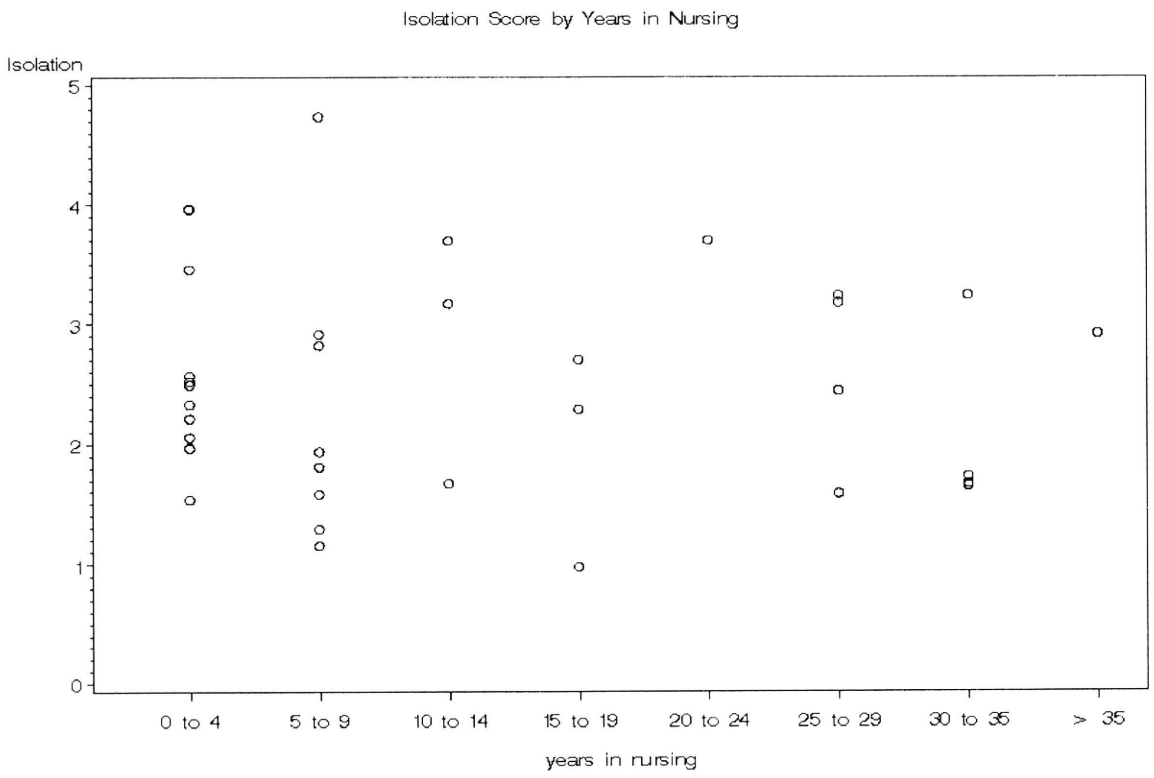
Highest level of education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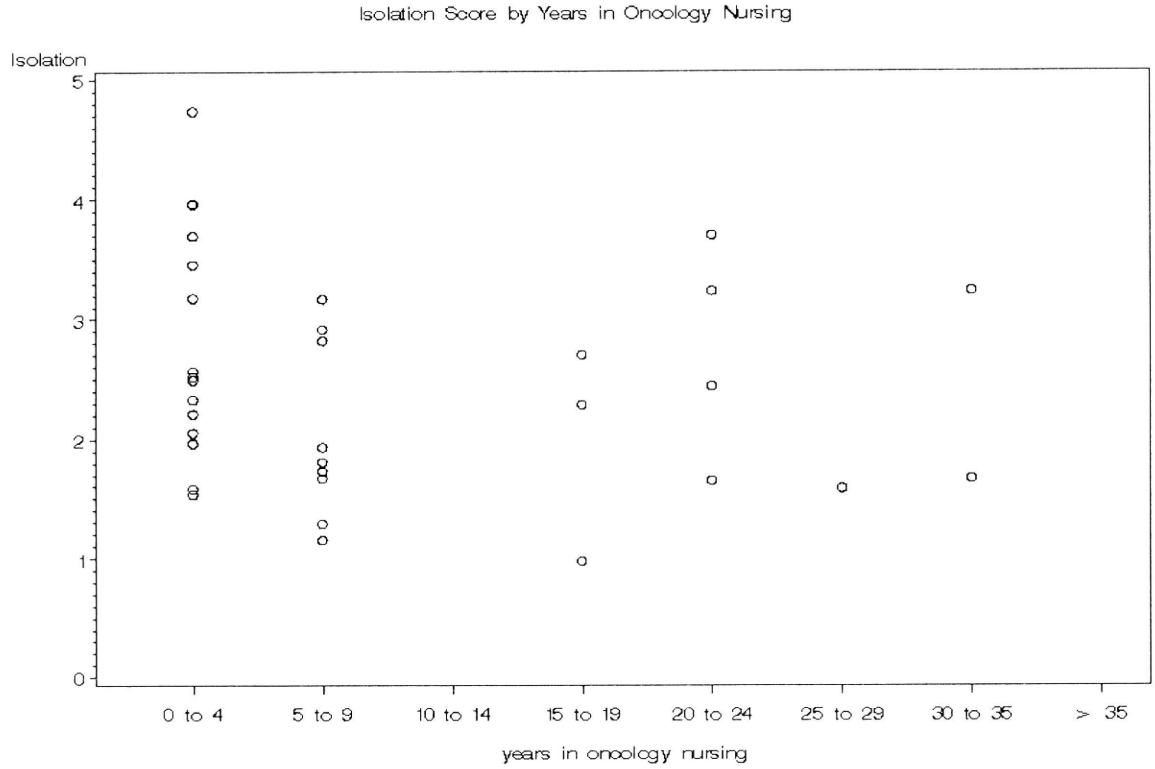
years in nursing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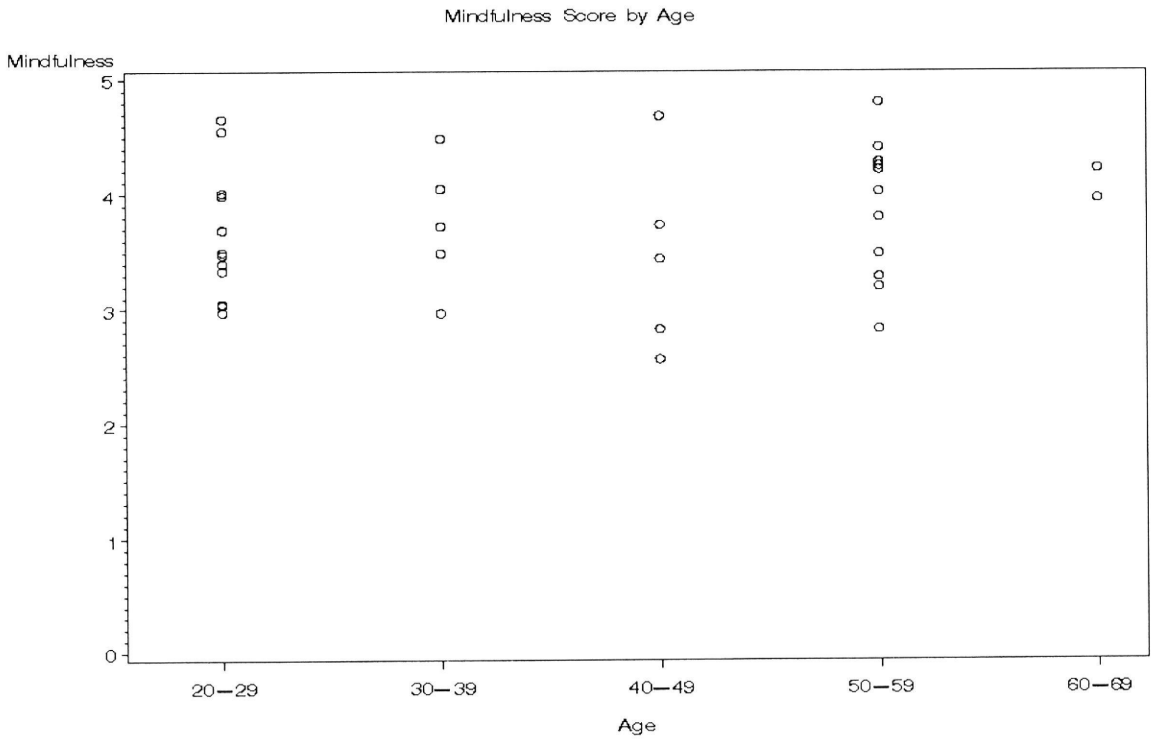
years in oncology nursing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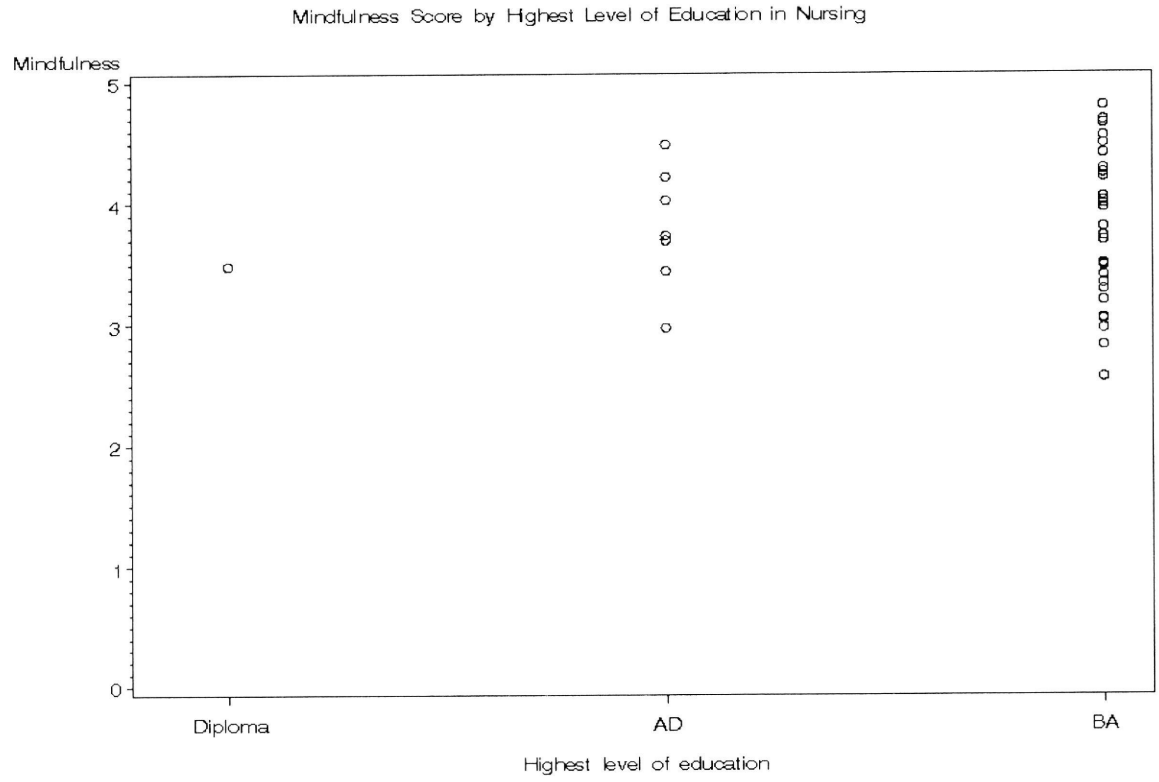
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Diploma
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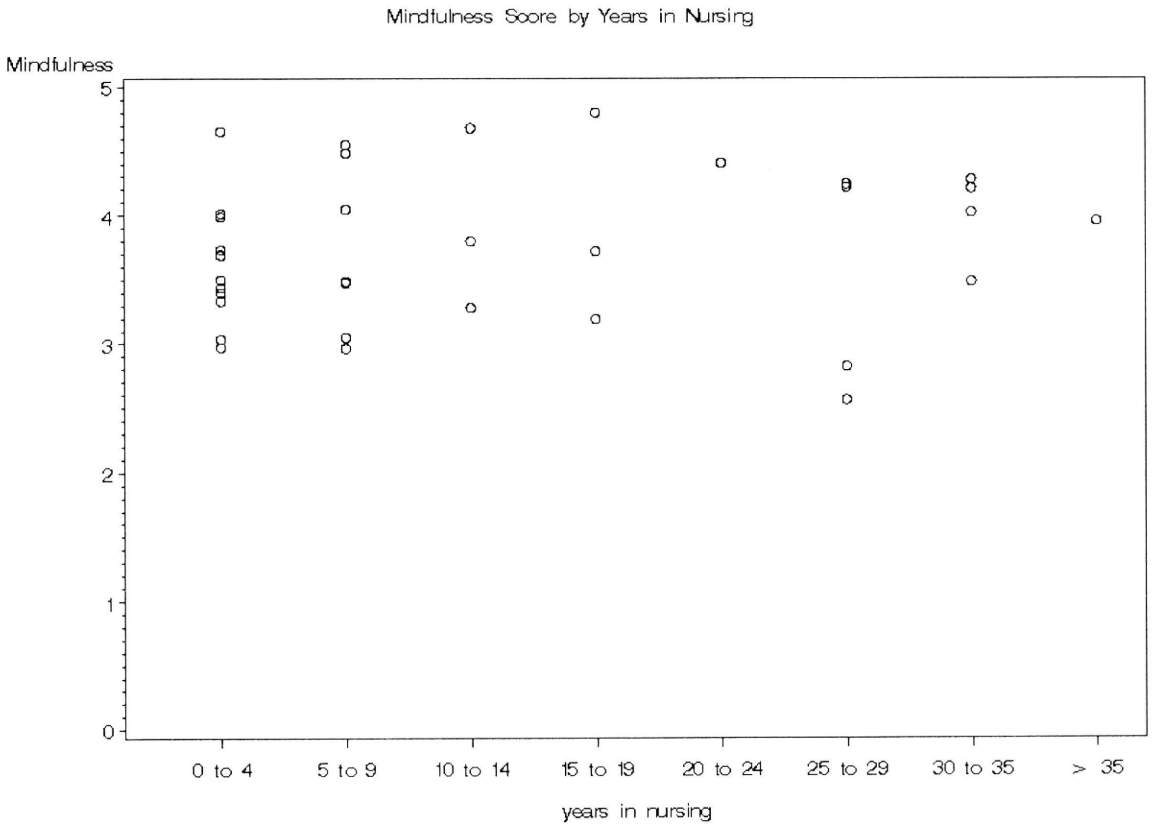
BA
Highest level of education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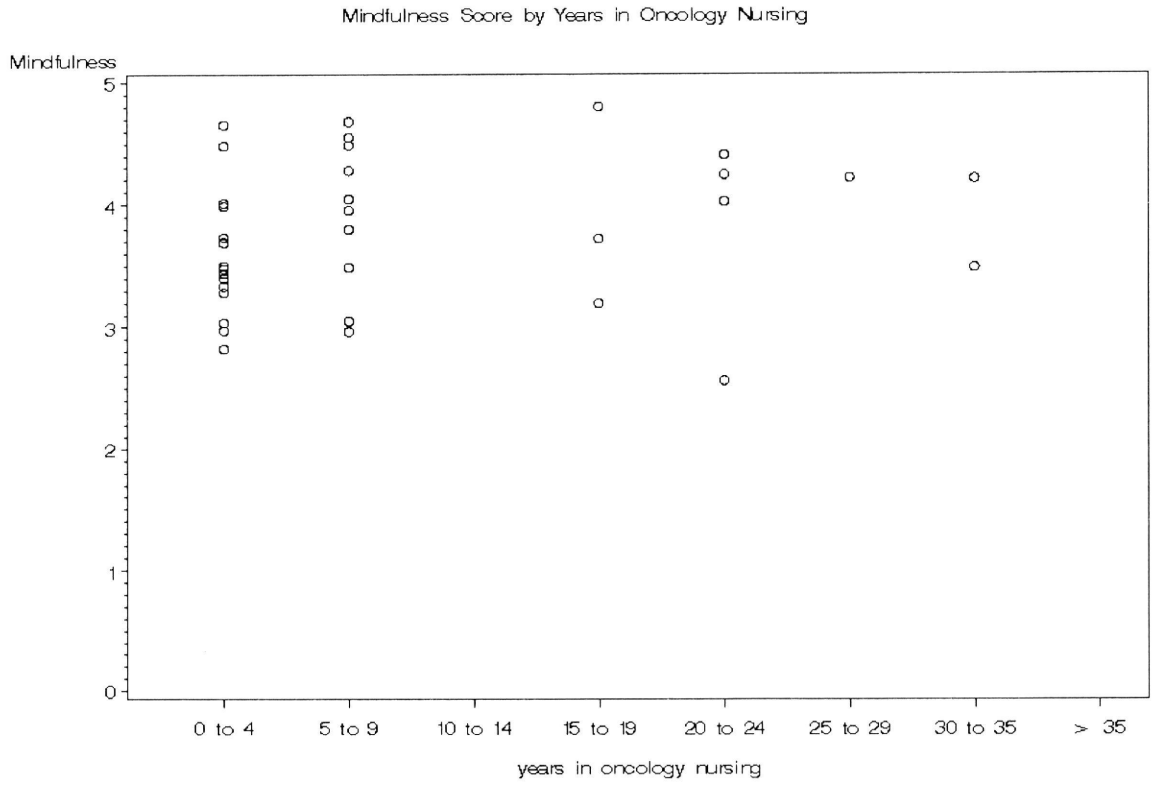
> 35
years in nursing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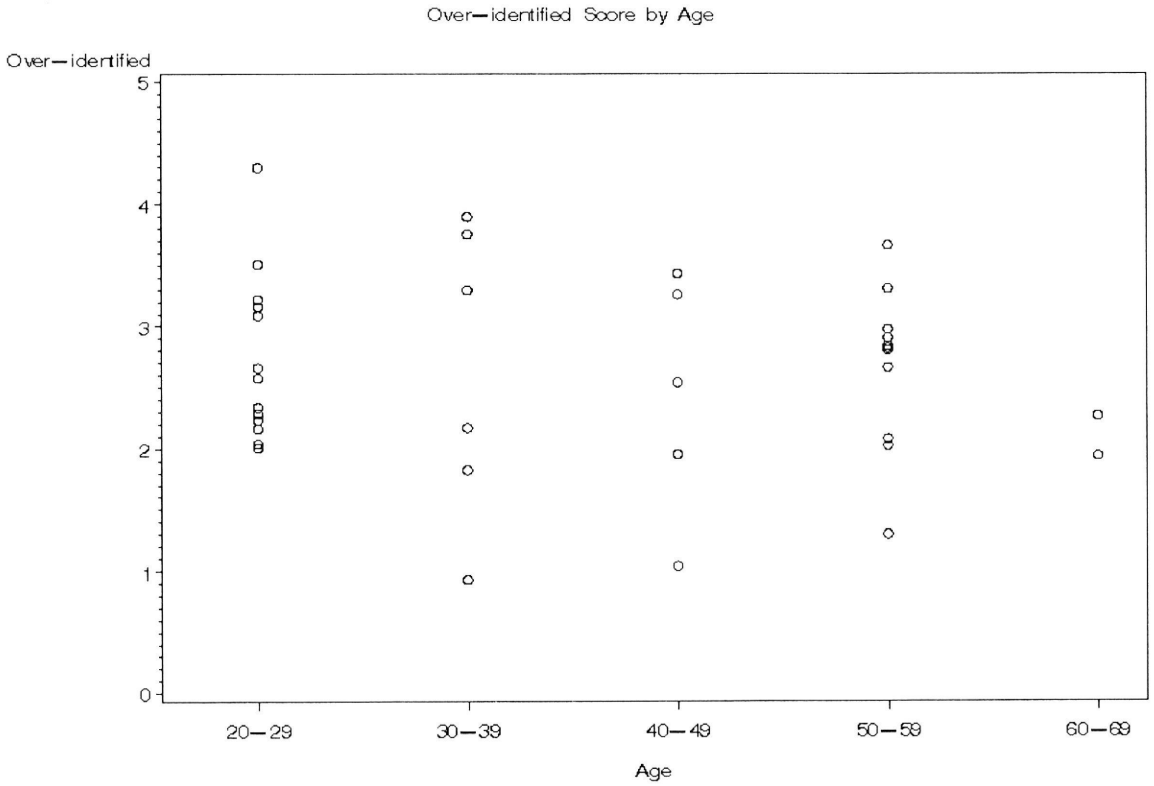
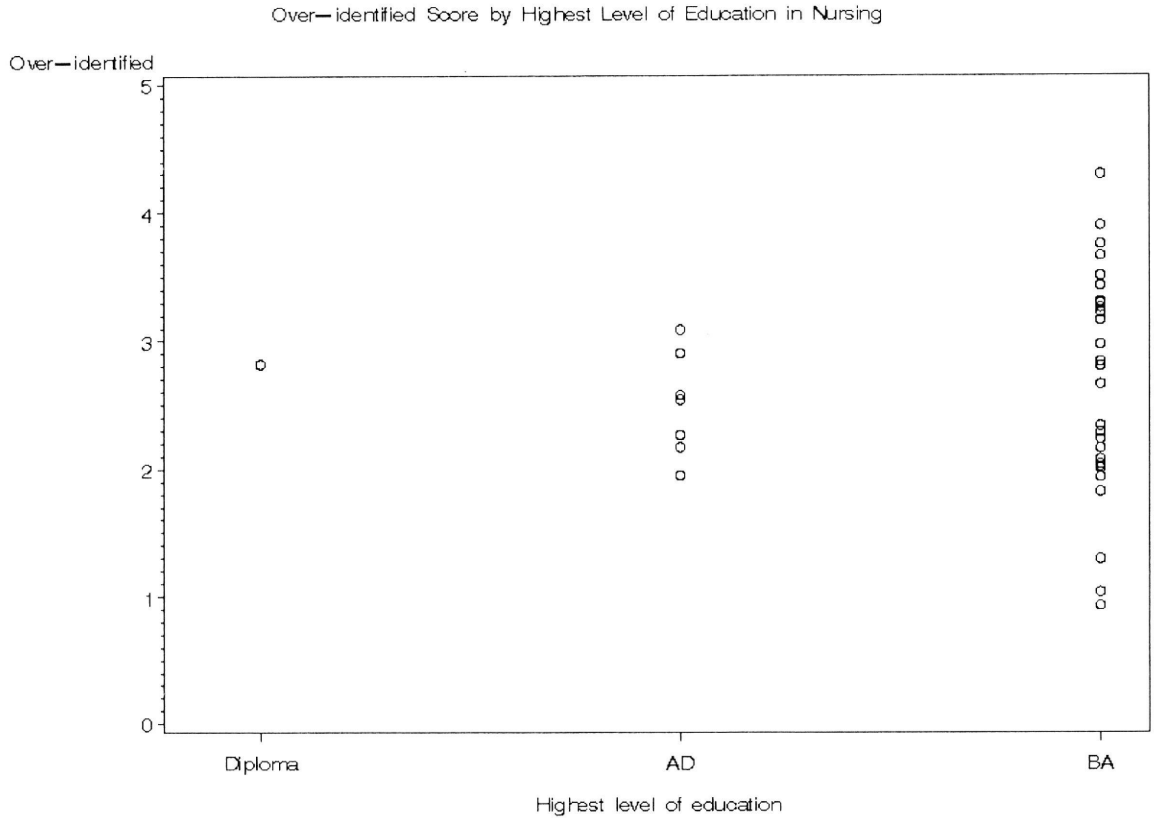
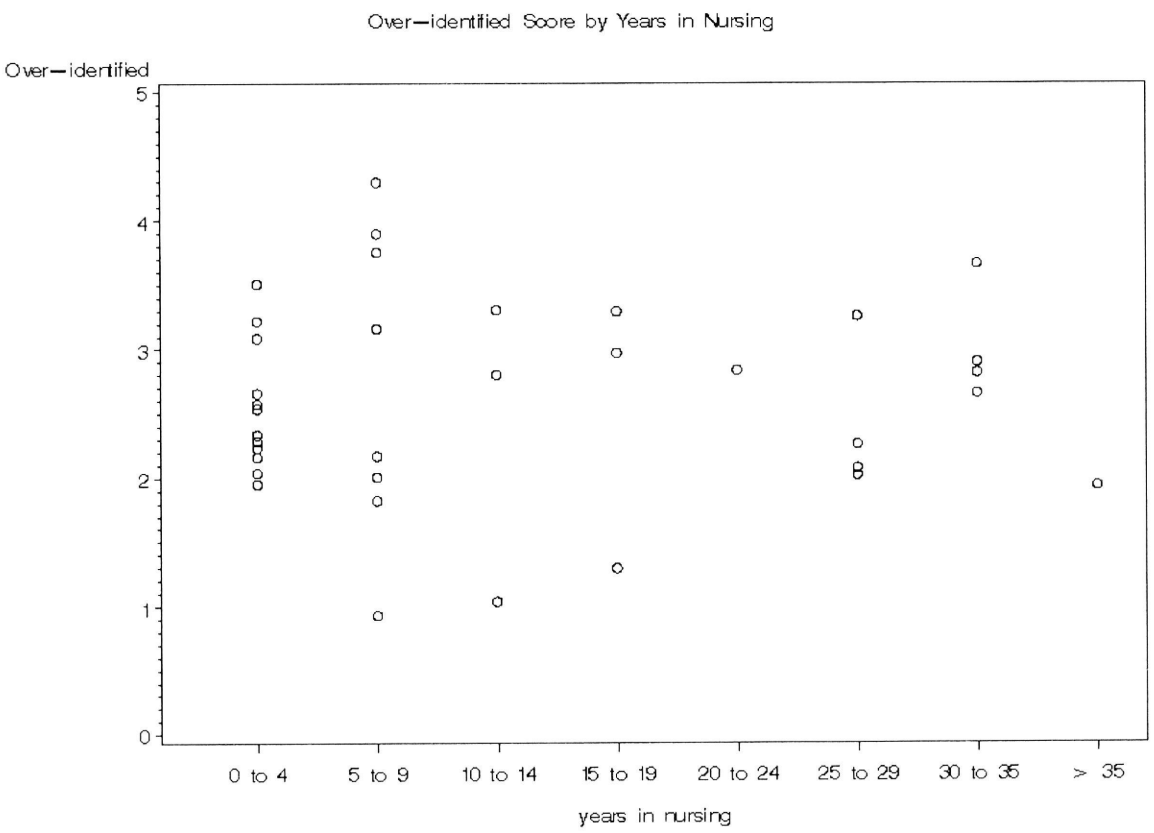
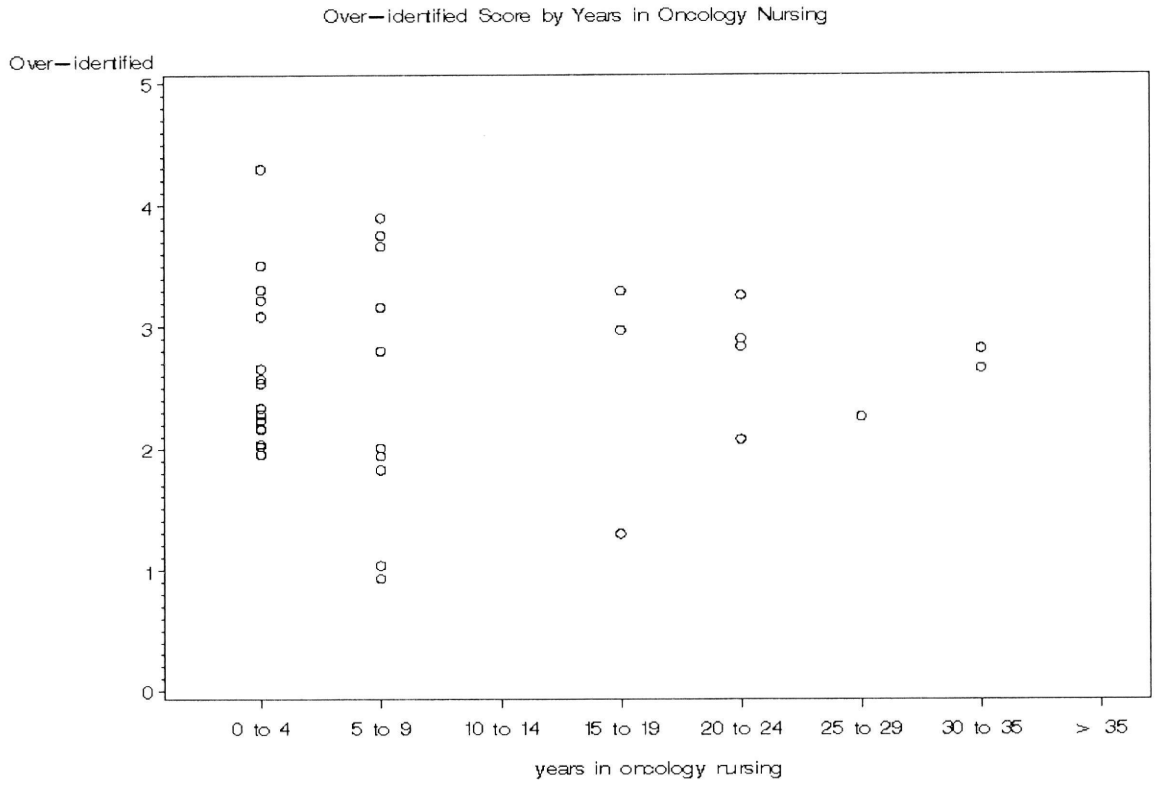
30 to 35
> 35
years in oncology nursing

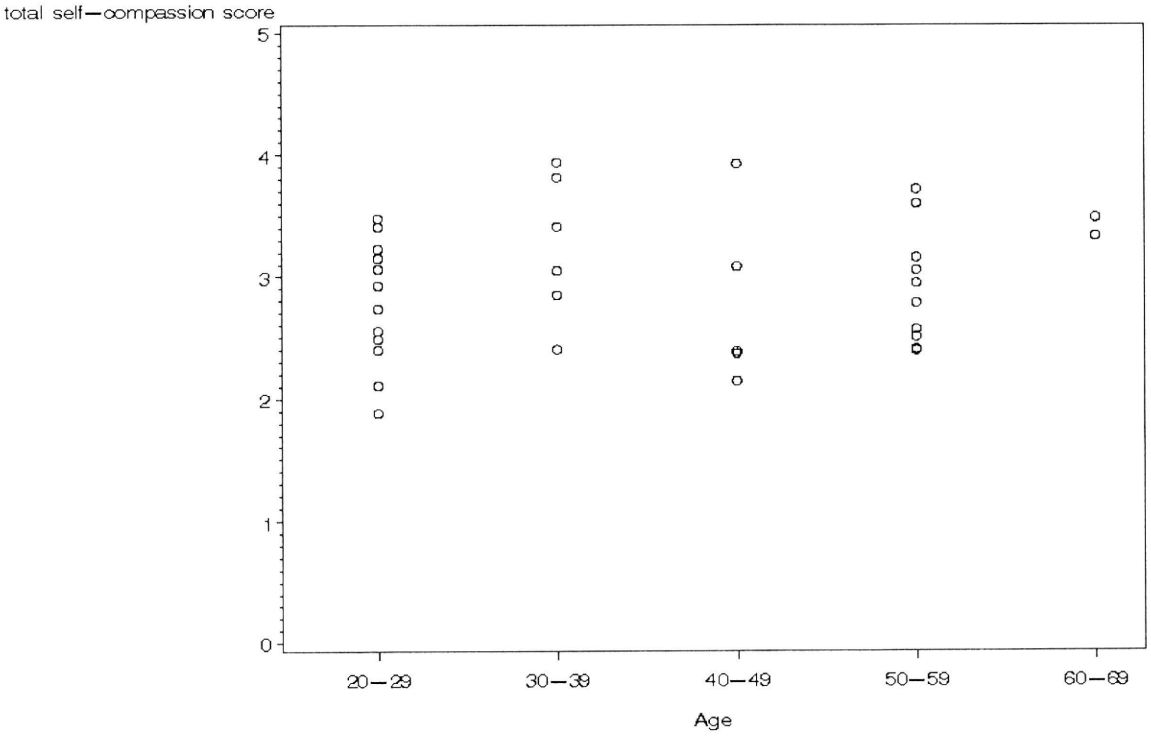

Over-identified Score by Age
Over-identified
5
4
3
2
1
0
20-29
30-39
40-49
50-59
60-69
Age


Over-identified Score by Highest Level of Education in Nursing
Over-identified
5
4
3
2
1
0
Diploma
AD
BA
Highest level of education

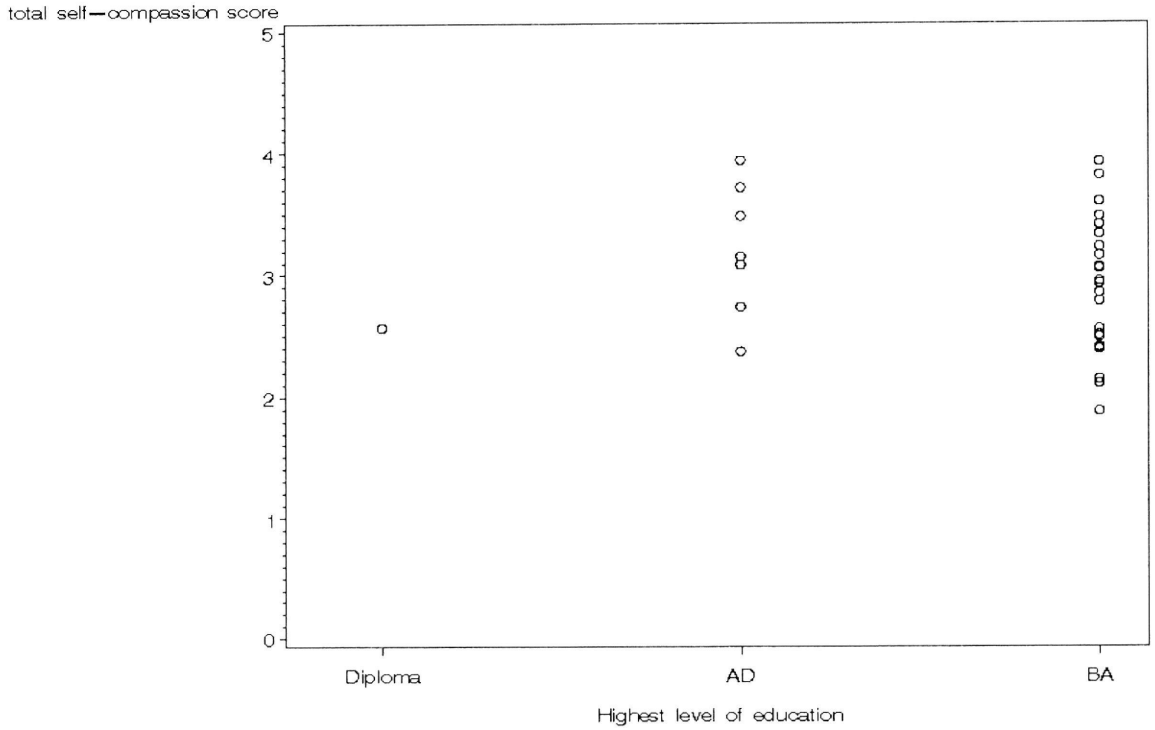

Over–identified Score by Years in Nursing
Over–identified
5
4
3
2
1
0
0 to 4
5 to 9
10 to 14
15 to 19
20 to 24
25 to 29
30 to 35
> 35
years in nursing


Over–identified Score by Years in Oncology Nursing
Over–identified
5
4
3
2
1
0
0 to 4
5 to 9
10 to 14
15 to 19
20 to 24
25 to 29
30 to 35
> 35
years in oncology nursing

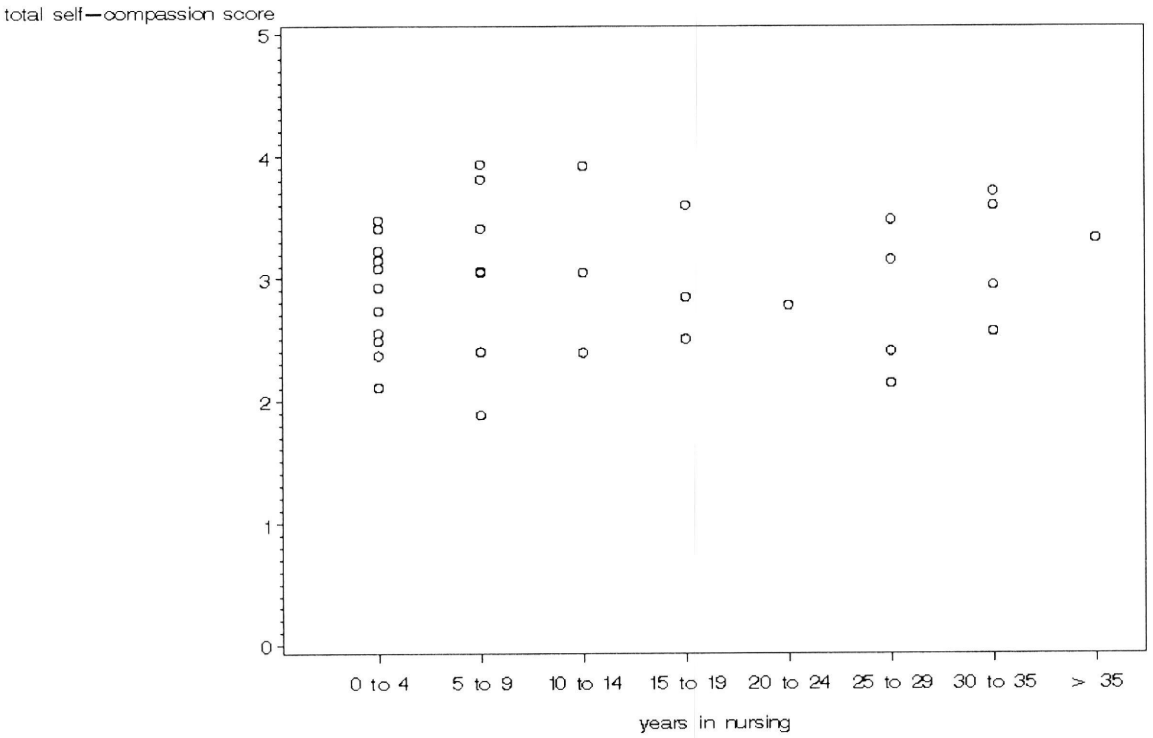
Total Mean Self—Compassion Score by Age



Total Mean Self—Compassion Score by Highest Level of Education in Nursing



Total Mean Self—Compassion Score by Years in Nursing



Total Mean Self—Compassion Score by Years in Oncology Nursing